House of Commons

Health Committee

SEXUAL HEALTH

Minutes of Evidence
Wednesday 26 June 2002

DEPARTMENT OF HEALTH

Ms Cathy Hamlyn

Dr Vicki King

Ms Ruth Stanier

Ms Kay Orton

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HC 990–i, Session 2001–02

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MINUTES OF EVIDENCE

TAKEN BEFORE THE HEALTH COMMITTEE

WEDNESDAY 26 JUNE 2002

Members present:

Mr David Hinchliffe, in the Chair

Mr David Amess	Sandra Gidley
John Austin	Siobhain McDonagh
Andy Burnham	Dr Doug Naysmith
Mr Simon Burns	Dr Richard Taylor
Julia Drown	

Memorandum by the Department of Health

SEXUAL HEALTH AND HIV STRATEGY (SH 1)

Introduction

1. The first ever, national strategy for sexual health and HIV was published for consultation on 27 July 2001. The strategy proposes a comprehensive and holistic model for modernising sexual health services in line with the principles set out in the NHS Plan.

2. The NHS Plan set out the Government's plans to develop a health service for the 21st century, offering fast, high quality and patient centred care. The core principles underpinning the NHS Plan form the basis of the key aims and objectives of the Sexual Health and HIV Strategy. These include providing a comprehensive range of services, shaping services around the needs and preferences of individual patients, responding to the needs of different populations and continuously improving quality services.

3. Tackling poor sexual health is an important part of broader work to tackle health inequalities. Poor sexual health disproportionately affects disadvantaged communities, and there are inequities in service provision from area to area.

4. This memorandum presents an analysis of sexual health in England today, and sets out the action the Government is taking to tackle the main problems identified.

Sexual Health in England today

Sexually Transmitted Infections and HIV

5. In the year 2000, there were over 1.1 million visits to Departments of genito-urinary medicine (GUM) in England. The most common conditions diagnosed in Departments of genito urinary medicine (GUM) were chlamydia, non-specific urethritis and wart virus infections. New diagnoses of sexually transmitted infections (STIs) such as gonorrhoea, chlamydia and syphilis are currently showing an upward trend[i].

6. An estimated 33,500 people in the UK were living with HIV at the end of 2000, of whom 72 per cent were aware of their HIV status. About 400 people a year die as a result of their HIV infection. Although there is still no cure, combined therapy has improved the life span of people living with HIV. For the last three years the number of new infections acquired through heterosexual sex has outnumbered those acquired through homosexual sex, and over 80 per cent of heterosexual infections were probably acquired abroad. Sex between men remains the major transmission route for HIV in this country[ii].

7. The average lifetime treatment costs for an HIV positive individual is calculated to be between £135,000 and £181,000[iii], and the monetary value of preventing a single onward transmission is estimated to be somewhere between £1/2 and 1 million in terms of individual health benefits and treatment costs.

International comparisons

8. France, the Netherlands, Sweden and Switzerland all reported increases in gonorrhoea between 1995 and 1999[iv] particularly among men having sex with men. The same group has also suffered outbreaks of syphilis, for example new diagnoses doubled in Sweden between 1996 and 1999. Between 1995 and 2000, new diagnoses of sexually acquired HIV infections increased by 20 per cent in Western Europe and numbers of people living with HIV are rising by around 3 per cent a year.

9. Data from the UNAIDS Report on the Global HIV/AIDS epidemic (June 2000) shows that at the end of 1999, the UK had an HIV rate of 0.11 per cent compared to rates of 0.74 per cent in Portugal, 0.58 per cent in Spain and 0.44 per cent in France. This reflects prompt action on a number of fronts: health promotion, needle exchange schemes and other harm minimisation initiatives, screening of blood and clinical interventions, the availability of open-access GUM clinics and careful surveillance and analysis of trends.

Sexual behaviour & knowledge

10. Studies suggest there has been an increase in risky sexual behaviour, and that there is still ignorance about the possible consequences. The average age at which people start having sex is now 16. Forty years ago it was 21 for women and 20 for men[v]. In 1999 most people questioned in a national study did not know what chlamydia was[vi].

11. Further important data have recently been published from the National Survey of Sexual Attitudes and Lifestyles (Natsal 2000)[vii], which can be compared with information from a similar survey undertaken in 1990. This showed that between the two surveys there had been an increase in behaviours associated with increased risk of HIV and STI transmission, including increases in numbers of partners and concurrent partnerships. In particular, there were considerably higher rates of new partner acquisition among those younger than 25 years and this is reflected in the substantially higher incidence of STIs in this age group.

12. Natsal also recorded increases in consistent condom use, which were greatest for men with multiple partners in the last year. Four in five 16 to 24 year olds used a condom at first intercourse and around 90 per cent used some form of contraception. These are significant increases from 1990 when over a third of teenagers reported not using any contraception at first intercourse. However, the increase in numbers of sexual partners may have offset some of the advantages of increased condom use.

13. A 1999 survey of gay men showed that 58 per cent of those under 20 did not always use a condom[viii]. A recent study indicated that 44 per cent of HIV positive men had anal sex with a new partner in the last month, of whom 40 per cent reported no or inconsistent condom use[ix].

Teenage pregnancy and unintended pregnancy

14. Sexual health is not just about disease. Ignorance and risky behaviour can also have profound social consequences. Planning parenthood, understanding contraception and the age of first intercourse can all have an important impact on individuals and communities. Teenage birth rates in the United Kingdom are the highest in Western Europe. Conception rates in England have now started to fall, the rate for under 18s and for under 16s having dropped by over 6 per cent between 1998 and 2000. This is encouraging, but the work being undertaken to implement the Teenage Pregnancy Strategy, such as improvements to Sex and Relationship Education and services for young people, will need to be sustained if the goal of a 50 per cent. reduction in rates by 2010 is to be achieved.

15. In 2001 there were nearly 176,000 abortions performed in England and Wales. Following a pill scare in 1995, abortion rates increased until 1998, but now appear to be stabilising. Abortion rates are highest for women in their early twenties and late teens.

16. It is estimated that the prevention of unplanned pregnancy by NHS contraception services saves the NHS over £2.5 billion a year.

Inequalities

17. Sexual ill health is not equally distributed among the population. The highest burden is borne by women, gay men, teenagers, young adults and black and ethnic minorities[x, xi]. The rates of gonorrhoea in some inner city black and minority ethnic groups are ten or eleven times higher than in whites[xii]. HIV infection also has an unequal impact on some ethnic and other minority groups. Britain's African communities have been particularly badly affected by HIV/AIDS, with high rates among both adults and children[xiii]. There is some evidence to suggest that chlamydia infection rates are associated with levels of deprivation.

18. There is a strong link between social deprivation and STIs, abortions and teenage conceptions. Unintended pregnancies increase the risk of poor social, economic and health prospects for both mother and child. The risk of becoming a teenage mother is almost 10 times higher for a girl whose family is in social class V (unskilled manual), than those in social class I (professional).

NATIONAL STRATEGY FOR SEXUAL HEALTH AND HIV

Development of the Strategy

19. In May 2000 it was announced that the HIV/AIDS and sexual health strategies had been integrated into a single programme. The aim of combining the two strategies was to develop more coherent health promotion messages and more effective service interventions for sexual health, including HIV/AIDS.

20. A new process for developing the combined strategies was established, building on existing structures and work to date, and bringing in additional expertise as required. An Integrated Strategy Steering Group was established (membership attached) together with various sub-groups and working groups to look at specific issues.

21. A wide range of stakeholders was also involved in the development of the strategy. A written consultation with health professionals working in the field was undertaken and meetings held with the Royal Colleges, professional organisations and other key players. There were specific consultations held with young people, black and ethnic minority groups and gay men and lesbian women.

Publication of the Strategy

22. The Strategy was launched for consultation on 28 July 2001. It was backed by investment of £47.5 million to support a range of initiatives set out in the strategy. The main aims of the Strategy are to:

— reduce the transmission of HIV and STIs;

— reduce the prevalence of undiagnosed HIV and STIs;

— reduce unintended pregnancy rates;

— improve health and social care for people living with HIV; and

— reduce the stigma associated with HIV and STIs.

23. The Strategy proposes to achieve these aims by:

— providing clear information so that people can take informed decisions about preventing STIs, including HIV;

— developing a new information campaign for the general population;

— producing a sound evidence base for effective local HIV/STI prevention;

— developing managed networks for HIV and sexual health services, with a broader role for those working in primary care settings and with providers collaborating to plan services jointly so that they deliver a more comprehensive service to patients;

— evaluating the benefits of more integrated sexual health services, including pilots of one-stop clinics, primary care youth services and primary care teams with a special interest in sexual health;

— beginning a programme of screening for chlamydia for targeted groups in 2002;

— stressing the importance of open access to GUM services and, over time, improving access for urgent appointments;

— ensuring a range of contraceptive services are provided for those that need them;

— addressing the disparities that exist in abortion services across the country;

— increasing the offer of testing for HIV to ensure earlier access to treatment for those infected and limiting further transmission of the virus;

— increasing the offer of hepatitis B vaccine;

— setting standards for the treatment of STIs and for the treatment, support and social care of people living with HIV;

— setting priorities for future research to improve the evidence base of good practice in sexual health and HIV; and

— addressing the training and development needs of the workforce across the whole range of sexual health and HIV services.

Consultation

24. The consultation period on the Strategy ran from 27 July to 21 December 2001. The Strategy was circulated widely across the NHS, voluntary organisations, Royal Colleges and social services.

25. The extended consultation period provided an opportunity for the Department of Health and other groups to organise a number of consultation events to supplement the written exercise. The Department of Health held six events in Warrington, London (two separate events), Bristol, York and Birmingham. These events were attended by a wide spectrum of health professionals and others from the field.

26. In addition we commissioned the Terrence Higgins Trust, Brook, the African HIV Policy Network and others to organise more targeted events. Other organisations such as the *fpa* and the National AIDS Trust also held events. The Royal College of General Practitioners held an event for GPs. Canvassing a wide range of constituencies was important and has helped us in developing implementation plans.

Summary of responses to the Strategy

27. We received over 400 detailed and thoughtful written submissions of very high quality. The large majority of people involved in the consultation welcomed publication of the Strategy. Many felt that the development of a strategic approach to improve sexual health is long overdue.

28. There was strong consensus around our analysis of the problem, in particular the rising trend of infections, the link between sexual ill health, poverty and social exclusion, and varying standards of service provision. There was also a large degree of support for the main interventions proposed, in particular the development of service standards to ensure consistent quality of care regardless of the point of access.

29. Many respondents were concerned about exactly how in practice the Strategy would be implemented, particularly following the mainstreaming of HIV funding. There were also strong views that improving clinical services—while important—would not of itself be sufficient. Implementation of the Strategy will require partnership working with other government departments, local government and the voluntary sector in order to succeed. There are limits to what a single organisation can achieve, particularly in seeking to change the behaviour of individuals.

30. Given the overall support for the aims, principles and interventions proposed in the Strategy, we do not propose at this stage to revise the Strategy itself. We are developing a response to the consultation and a detailed implementation action plan which will be published shortly. The Strategy taken together with the consultation response and implementation plan set out in this document will provide an overall framework for action.

Action taken during 2001–02

31. During 2001–02, alongside the consultation exercise and events, we invested £5.5 million to prepare for implementation of the Strategy as detailed below:

- We provided funding for every local area to undertake a baseline service mapping exercise, and identify gaps and weaknesses in existing services. These reports will be analysed and a summary report published in the autumn. (£1.6 million)
- We have started to develop the information campaign, including undertaking research on what works. We also supported the World AIDS Day HIV prejudice campaign. (£0.8 million)
- We have funded a study to investigate the incidence and re-infection rates of genital chlamydial infection in young women attending public health care settings in Portsmouth and Wirral. This will help to inform the design of the chlamydia screening programme, particularly screening intervals. (£0.6 million)
- We have funded a range of national and local interventions aimed at reducing the recent resurgence of syphilis in England. These include an awareness campaign for groups most at risk of syphilis, reviewing and updating of national enhanced laboratory surveillance for syphilis and improving outbreak management skills. We have also funded local interventions in London, Manchester and Brighton, which complement national initiatives, but are more targeted, appropriate and sensitive to local circumstances. We have also provided more doses of hepatitis B vaccine to GUM clinics. (£1 million)
- We provided funding to 16 further areas to start or expand schemes for pharmacy availability of emergency hormonal contraception under a patient group direction. (£0.75 million)
- We have taken forward other national initiatives, in particular the development of basic sexual health skills training for health professionals and introduction of a more efficient abortion data processing system. (£0.75 million)

IMPLEMENTATION ACTION PLAN

32. Our implementation action plan, to be published shortly, will set out in detail how we will work both through the NHS and in partnership with other Government Departments and the voluntary sector to tackle sexual ill-health. This is a long-term programme. We will need to both improve and modernise services, and also seek to change individuals' behaviour drawing on the best evidence on what works in achieving this. This will form an important part of our work to improve public health, tackle health inequalities and communicable diseases, and deliver the NHS Plan. The main strands of the implementation plan are summarised below.

33. The Implementation Action Plan will build on the arrangements already in place at national and local level to implement the Teenage Pregnancy Strategy, working in partnership with a wide range of organisations from the statutory and voluntary sector. The Plan will also link to implementation of the Infectious Diseases Strategy Getting Ahead of the Curve which identifies control of HIV transmission as a key priority.

Framework for delivery

34. Primary Care Trusts (PCTs) will play a central role in implementing the strategy. PCTs have a unique perspective across community, hospital and primary care and across both the NHS and local authorities. They also have a very clear relationship both with frontline staff and with patients. PCTs have been given new powers and control over resources to shape and commission services. These new powers will enable commissioning to be more responsive to local need and the views of service users.

35. We have asked PCTs to identify a sexual health and HIV lead to drive forward implementation at local level. We are encouraging PCTs to collaborate in commissioning consortia in order to make best use of existing expertise in sexual health and HIV commissioning. A key element of the implementation plan is the development of a Sexual Health and HIV Commissioning Toolkit to support PCTs in this new role.

36. We will carefully monitor levels of investment following the mainstreaming of HIV budgets. This will include revised arrangements for monitoring under the AIDS Control Act. Strategic Health Authorities will be responsible for performance managing implementation.

Better prevention

37. We are working towards launching a national information campaign in the autumn. The campaign will highlight the risks of unprotected sex, and will target young adults in particular. This will build on the success of the teenage pregnancy media campaign which has secured recognition of 78 per cent with its target audience, and good understanding of the key messages. We are also taking forward more targeted campaign work, including promoting HIV testing among high risk groups.

38. The Health Development Agency is undertaking a review of the evidence base for local HIV and STI prevention. The main findings will be disseminated to local areas by the autumn, supported by a regional seminar programme. We are also developing a health promotion toolkit to support implementation.

Better services

39. We will work with professional bodies and service users to develop and publish a set of recommended service standards. Work on updated standards for HIV treatment is already underway in partnership with the BMA Foundation for AIDS and other key partners. The updated standards will be published later this year. We will also disseminate details of effective managed service networks to upport implementation of the standards.

40. The national chlamydia screening programme will start to be introduced in 10 sites, selected from those areas which have expressed an interest. The programme will build on the learning from the successful pilots in Portsmouth and the Wirral. This will be an opportunistic screening programme which will primarily target women who access services, but will also promote greater uptake of testing among men.

41. We will start to address variations in abortion services, working towards a maximum waiting time of 3 weeks by 2005. We will also develop the role of health advisors within GUM services, informed by the recommendations from the Health Advisors Working Party, and will work towards shorter waiting times for urgent appointments. We are extending the availability of hepatitis B vaccine, and have recently notified GUM services of the arrangements for this.

42. We will develop three models for One Stop Shop sexual health services providing advice, contraceptive and GUM services on a single site. The models will cover youth services, specialist primary care teams and specialist services which meet the needs of all age groups.

Better support for people living with HIV

43. We will commission a report on the support needs of adults living with HIV, and develop services standards. This will include access to good quality sexual health advice and supporting adherence to drug regimes. We will also develop service standards to meet the support needs of children living with HIV. We are reviewing the administration of AIDS Support Grant, with the aims of minimising bureaucracy and ensuring the needs of people living with HIV are met.

44. Drawing on consultation responses, we will develop a more detailed action plan to tackle stigma and discrimination working in partnership with other Government Departments.

Supporting change

45. We are undertaking a mapping exercise of current availability of basic sexual health skills training and other professional training to inform a national sexual health training strategy. The strategy will encompass the training needs of doctors, nurses (including family planning specialists and school nurses), midwives, health visitors, health advisors, youth and social workers and other relevant professionals, and will link to the work on teacher training already underway as part of the Teenage Pregnancy Strategy.

46. The content of the joint Medical Research Council and Department of Health research programme is being reviewed to ensure that it effectively supports implementation of the Sexual Health and HIV Strategy. New projects to support the Strategy will be commissioned from 2003. Further annual reviews will be undertaken by the Medical Research Council on an annual basis, informed by progress on systematic reviews of the literature in relevant subject areas.

CONCLUSION

47. This is an ambitious and wide-ranging Strategy which sets out a long-term programme working towards safer sexual behaviour, modernised services and better sexual health for the whole population. Improving sexual health and changing behaviour is not something that can be brought about by the Department of Health and NHS services alone: other government departments, local government and the voluntary sector have a crucial role to play too.

48. Devolving new powers and resources to Primary Care Trusts provides an important new opportunity to make the commissioning of sexual health services much more responsive to local needs. Service users will be involved at both national and local level in redesigning services around their needs. This work will build on existing models of excellence in GUM, health promotion and reproductive health services which are highly responsive to users' needs and concerns, and have made such a major contribution to controlling the HIV epidemic in this country. By supporting local implementation and building a broad partnership to drive forward the Strategy, we can succeed in reversing the upward trend of infections, tackling inequalities and modernising sexual health and HIV services.

Annex: Members of Sexual Health and HIV Strategy Integrated Steering Group

Professor Michael Adler, Professor of Genito-urinary Medicine at Royal Free and University College Hospital Medical School, Chair
Dr Sheila Adam Deputy Chief Medical Officer/Health Services Director, Chair

Dr George Kinghorn, Clinical Director —GUM Department, Royal Hallamshire Hospital

Dr Connie Smith, Consultant and Clinical Director, Parkside Services for Women and Head of Clinical Effectiveness Unit Faculty of Family Planning and Reproductive Healthcare.

Dr Patrick French, Consultant in GU Medicine, Mortimer Market Centre

Gill Frances, Manager of Children's Personal Development Unit, National Children's Bureau

Nick Partridge, Chief Executive, Terrence Higgins Trust Lighthouse

Derek Bodell, Chief Executive, National AIDS Trust

Martin Roberts, Chief Executive of Lambeth, Southwark and Lewisham HA

Joshua Odongo, Chair, HIV Policy Network

Anne Weyman, Chief Executive, fpa

Ian Kramer

Dr Chris Ford, Royal College of General Practitioners

Steve Jamieson, Royal College of Nursing

Paul McCrory, Chair, Network of Self Help HIV and AIDS Groups

Dr Roger Ingham, Centre for Sexual Health Research, University of Southampton

Baroness Doreen Massey

Jo Adams, Manager, Sheffield Centre for HIV and Sexual Health

Simon Blake, Director, Sex Education Forum

Dr David Hawkins, John Hunter Clinic

Mark Blake, Director, Blackliners

Dr Sian Griffiths, Director of Public Health, Oxfordshire Health Authority

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Examination of Witnesses

Ms Cathy Hamlyn, Head, Sexual Health and Substance Misuse, Dr Vicki King, Head, Blood and Healthcare Associated Infections Unit, Ms Ruth Stanier, Deputy Head, Sexual Health and Substance Misuse, Ms Kay Orton, Team Leader, HIV and Health Promotion, and Ms Andrea Duncan, Acting Team Leader, Sexual Health, Department of Health, examined.

Chairman: Colleagues, can I welcome you to this first meeting of the Committee's inquiry into Sexual Health, and particularly welcome our witnesses; we are very grateful for your co-operation with our inquiry. As this is the first meeting of this inquiry, we normally do require any declarations of interest that may be relevant to the inquiry.

Julia Drown: As we say in other inquiries, there are bound to be some people working in this field who are UNISON members.

Chairman: Okay; well I will declare the fact I am a UNISON member and receive support from UNISON at general election times.

Julia Drown: Or your constituency does; likewise.

Andy Burnham: I declare likewise.

Sandra Gidley: Indirectly, I think I ought to declare, I am a member of the Royal Pharmaceutical Society, which may be regarded by some as an interest, maybe getting some election expenses.

Chairman

1. Thank you very much. Could I ask each of our witnesses to briefly introduce themselves to the Committee, starting with you, Ms Orton?

(*Ms Orton*) Kay Orton. I work in the Sexual Health and Substance Misuse team in the Department, and my interests are around HIV, including HIV prevention, and health promotion.

(*Dr King*) I am Vicki King. I am a microbiologist and I work in the Communicable Diseases branch of the Department of Health. And I am Head of a unit which is entitled Blood and Healthcare Associated Infections Unit, and that also covers hepatitis B and C and some aspects of HIV.

(*Ms Hamlyn*) I am Cathy Hamlyn. I am Head of Sexual Health and Substance Misuse in the Department of Health. I am responsible for implementation of the Sexual Health and HIV Strategy, and I am also responsible for implementation of the Teenage Pregnancy Strategy.

(*Ms Stanier*) I am Ruth Stanier. I am Cathy Hamlyn's Deputy.

(*Ms Duncan*) I am Andrea Duncan. I work with Cathy and Ruth, and I work on reproductive health and STIs.

2. Thank you very much. What I wondered if we could start with is a brief question on how the different elements of relevance to sexual health within the Department knit together, structurally, and how perhaps the different elements within Government knit together in the development of a strategy on sexual health? I do not know who would like to tackle that, as a starter?

(*Ms Hamlyn*) When the strategy was actually being developed, there were separate branches within the Department of Health who dealt with teenage pregnancy and who dealt with sexual health, which included HIV, promotion, prevention and, indeed, HIV treatment was dealt with by a separate branch, but that has now all come together, it has all come together under me; but I also deal with substance misuse, and obviously there is a link with drug-injecting, drug users. That has now all come together in one entity under me in the Department of Health, but we work very closely with the Communicable Diseases branch, and Vicki has already explained some of her responsibilities, in that respect. Now this was developed very much as a Department of Health strategy, but clearly there are a lot of linkages across Government. The Teenage Pregnancy Strategy is a cross-Government strategy, and we already have a cross-Government Interdepartmental Officials Group, as well as linking into ministerially, through the ministerial groups on children and young peoples services, and social exclusion, those two ministerial committees. What we have done since the strategy was initially developed, and through the consultation, is to build upon our links, and we already have good bilateral links with a number of other Government Departments, which we have done routinely over quite a number of years, whether that is the Home Office, whether that is DFID, whether it is the Department for Education and Skills, and the Department for Education and Skills are very keen, for example, for sex and relationships education as part of the Teenage Pregnancy Programme. And it is our intention to build upon the interdepartmental group that we have for teenage pregnancy now, to build upon that in order to take forward the cross-Government focus which this strategy is being developed as, and, indeed, I hope that you would agree is reflected in our Action Plan recently published. So we have a number of different mechanisms for good working across Government, which we intend to build upon.

3. Thank you. The problem, in relation to STIs has been pretty apparent for some time, and obviously, as a Committee, one of the reasons that we are looking at this area is because of the concern over the rising extent of problems in this area. Without getting into the political side of this, and I appreciate that would be inappropriate to ask at this stage, we may ask Ministers, why has it taken till 2001 to develop a national strategy; what would you identify as the kind of key influences behind the development of a strategy, from your own point of view within the Department?

(*Ms Hamlyn*) This is clearly a serious and significant public health issue, and, yes, it is the first Government strategy that has really tackled sexual health and HIV; and originally those two were being developed separately, and they come together in this one strategy. And it is in the context of the increasing and rising trend in sexually-transmitted infections, that has been very apparent over the last few years, and the increasing prevalence in HIV. There is a lot of work done on HIV by the Department, but we

[**Chairman** *Cont*]
need to have a renewed effort, given that we are seeing an increased prevalence of HIV, in particular, the new diagnoses in 2001 increases over 2000 that we are seeing an increase in, the greatest proportion now being through heterosexual transmission, although the greatest proportion of those are being acquired abroad. So it is very much in the context of those rising trends, and, indeed, we need to have a renewed emphasis on HIV. There is also the context of very apparent pressures on services, and, indeed, a number of issues that have come up through the consultation, through the development of the strategy, and, indeed, the subsequent consultation on pressure of services, increases in waiting times, whether that is talking about GUM or the problems around abortion. I think it is in recognition of all of those issues, about the importance, therefore, of having a strategy that really pulls together and really starts to tackle these issues.

4. It just seems a bit strange that we have had a National Health Service since 1948, and we have had significant problems in this area over that period of time, which has impacted in many ways on the Health Service, and I have mentioned to some colleagues previously that, certainly, working in the mental health sector, I came across people who had mental health problems arising from a sexually-transmitted disease, and I am sure you are aware of the nature of that problem. It just seems very surprising to me that we have taken so long to actually sit down and develop some coherent thinking at Government level on this issue. I am not being critical of you, you were not around over all that 50-year period. I just wonder what your thoughts are as to why we have suddenly become aware, far more aware, than we have been previously, when, presumably, years and years ago, we could have been developing some of the ideas that you have come up with now, that would have made a difference to a significant number of people?

(*Ms Hamlyn*) I cannot speak to the history, as you quite rightly said, and I only joined the Department myself a couple of years ago, so I could not speak on that history; some of my colleagues may be able to comment further. But I would not like you to go away thinking that there were not a lot of things going on.

5. I appreciate that. We are talking about a national strategy, of course?

(*Ms Hamlyn*) Yes; there was not an overall national strategy which brought those issues together, but there was a lot of work going on in terms of health promotion; the Health Education Authority, as it was then, had been doing a lot of work on sexual health, we had campaign work going on, we had both on HIV in general and targeted health promotion had been going on. So I would not like you to think that it was not—yes, this is the first time there has been a strategy that brought all those things together.

6. Do any of your other colleagues want to come in on that general area: Dr King?

(*Dr King*) I could perhaps say something on that, a little bit about the historical context. I think the whole area of STIs, and HIV, of course, came much more into focus after the first AIDS cases, they are described in the States and then in this country, so we are talking about 1981/1982. So that clearly brought it all into focus, and a number of certainly health promotion initiatives came about then, that I think we are still reaping the benefit of, if we actually compare the prevalence of HIV in this country with the prevalence in other countries that perhaps did not take those initiatives quite as early, in the mid 1980s.

Sandra Gidley

7. The Sexual Health Strategy, I just wondered if it, in effect, was slightly misnamed, because it concentrates, probably quite rightly, on HIV and STIs, but if you look at sexual health in the wider sense then perhaps you should also be covering in more depth areas like sexual dysfunction, whereas, in fact, I think, if you read the strategy, it was one paragraph on the subject, if that. Now when we get very exercised by the figures on sexually-transmitted diseases, and I think they are shocking, we do need something to be done about them, there a lot of people out there, and the figures are not collected, who suffer from problems with sexual dysfunction, yet they seem to ignore it, because it is not a target that can easily be met. Why is there scant attention paid to that area in the strategy?

(*Ms Hamlyn*) There is, within our Action Plan, a clear commitment to develop standards, in respect of psycho-sexual services, that include sexual dysfunction, and, more broadly, as I say, there are other standards actually mentioned in there and overall clinical practice guidance, so it is an area that we will be developing further, with those standards being developed and widely disseminated to the service.

Chairman

8. Can I mention, before I pass on to some of my other colleagues who want to come in with questions, one of the bits of evidence that we have received in this inquiry, from the Medical Foundation for AIDS and Sexual Health says, and I quote: "the nation's sexual health is deteriorating". Is that an impression that you have, in your position, of the overall picture?

(*Ms Hamlyn*) I do not think we can deny the increasing prevalence in, as I was mentioning, sexually-transmitted infections and HIV, I do not think we can deny the facts as they speak for themselves, and we have seen, over the last five years, increases in gonorrhoea, chlamydia, syphilis, of over 100 per cent, and those increases are still going on. So I do not think we can at all deny that we need to address those issues, and, indeed, that is why we have a strategy to do so.

9. But you would not necessarily say it is deteriorating?

(*Ms Hamlyn*) It is not getting any better.

Chairman: Well, that is an interesting answer.

Andy Burnham

10. Just on that point, can I ask you a few questions about young people, in particular, and ask you whether the nation's deteriorating sexual health is linked to a change in attitudes amongst younger people? From figures which the Committee have been given, from the National Survey of Sexual Attitudes and Lifestyle, it portrays fairly big increases in sexual activity, including numbers of partners, and just generally people seem to be more sexually active, and active at a younger age as well. Is that a fair assessment of changing habits amongst young people?

(*Ms Hamlyn*) I think we do need to set this in proportion, but the average age of first sex is not dissimilar to other countries. Between the last ten years, in respect of the Natsal study, it showed there was, in fact, a difference in the age of first sex from 17 to 16, that is the difference; there are still only about a third who have sex before 16.[1]

11. It says in the figures we have though, if you do not mind me interrupting, quickly, that age at first intercourse for women has fallen from 21 to 16?

(*Ms Hamlyn*) Yes; over a period, that is true. If you went right back to earlier last century, in the 1920s, you would probably have been talking about only 1 in 25, 1 in 20, who had sex before the age of 16; that has changed over time, I think we recognise that. There are a couple of other things in that, that I think are significant as well, and again colleagues may wish to comment further, that young people were acting, you could say, more responsibly during that period, that, in fact, condom use has increased, the figures quoted in the previous Natsal were that only something like 50 per cent of under-16s and 66 per cent of 16-19 year olds were using condoms at first sex, and that figures has now improved to 80 per cent, so there is a greater awareness of the need to act responsibly, if you are going to be sexually active. But that has been, to some extent, counteracted by the fact that, yes, Natsal was also saying, as you quite rightly say, there are increases in the number of partners. So there are differences there. A lot, obviously, of what we are doing in relation to under-18s is being picked up as part of the Teenage Pregnancy Programme. Clearly, one of our priorities now, in the context of the Sexual Health Strategy, is to look at young adults, and that is really where the biggest increase in sexually-transmitted infection rates is, really from the age of 16 up to 34, so that is very much a strong focus.

12. And could I just ask, is my assumption that, over the course of the last century, there was an ever-increasing trend towards more and earlier sexual activity by young people, and that it is not cyclical but it is just becoming more and more and more and more, as we move on? However, in terms of looking at the history of society, going back centuries, does this move in cycles, or is the evidence that we are becoming a more promiscuous society?

(*Ms Hamlyn*) I think there are differences between talking about age of first sex and talking about promiscuity, I think there are differences between those two things. What I was referring to was, in fact, yes, the age of first sex has undoubtedly come down, it has come down in other countries as well, and it had come down over a number of years, over that period. I think that is rather different from talking about promiscuity.

13. But do you think there will be a backlash, at any point, that the moral climate changes, or do you think that—

(*Ms Hamlyn*) I am not sure I am in a position to predict what will happen in that respect. What we are trying to approach is to give people the information, because certainly for young people it is about giving them the information they need to make the right choices for them; you want to ensure that young people do not feel pressurised to have sex early, that they are given the skills that they can indeed say "no" when they do not feel it is right for them. Indeed, there is a lot of misinformation, there is an assumption amongst the young peer group that everybody else is doing it, when in fact that is clearly not the case.

14. Are you confident, in the Department, that you are doing enough to track and to tap into what young people are thinking and saying about sex amongst themselves, and actually what they are doing at weekends? Do you have the mechanisms within the Department to monitor those trends?

(*Ms Hamlyn*) We have quite a number of different mechanisms around young people themselves, in terms of them telling us about what some of the issues are. And within the Teenage Pregnancy Programme we commissioned Barnardo's to bring together the best possible evidence about how you involve young people; we put that together into a guide, and backed that up with training across the country, in a number of seminar programmes. We also have, through the support of the National Children's Bureau, a Young People's Forum, and the National Children's Bureau, also on our behalf, carry out targeted consultations with particular, different groups of young people, and they could be young people in care, young offenders, and so on. So we have quite a lot going on within the Teenage Pregnancy Programme. Within the context of the development of the Sexual Health Strategy, in the early days of developing the strategy, there were a number of events specifically with young people, and then, subsequently, we supported work in doing a targeted consultation on the strategy document itself, with young people. Also, within the context of the development of the campaign within the Teenage Pregnancy Programme, we did some thorough research, drawing together the best possible evidence about what works with young people, and on public health campaigns in general, both here and abroad, that are specifically in respect of sexual health, and drew on not just looking at what works, in terms of increasing knowledge for changing behaviour, but we also looked at lifestyle issues, as part of that. And, similarly, we commissioned and received the same type of research for the younger adults, up to age 30. And with our teenage pregnancy advertising campaign, in fact, we test all our adverts with young

[1] *Note by witness:* Data from NATSAL 2000, published in the *Lancet* on 1 December 2001, showed that the proportion of those aged 16–19 years at interview reporting first heterosexual intercourse at younger than 16 years was 30 per cent for men and 26 per cent for women.

[**Andy Burnham** *Cont*]
people before they go, so we get a real feedback. And as part of the national evaluation of the Teenage Pregnancy Programme, we have a tracking survey with young people, we have it with parents too, but we have it with young people, where we have 700 young people three times a year, we are testing their knowledge, their attitudes, over time, we will be able to track where we can see changes in attitudes, behaviour.

15. On teenage pregnancies, why do you think it is that Britain traditionally has had an extremely high rate, indeed, the highest in Europe, what factors would you identify, say, three or four, as to why we have always led the way?

(*Ms Hamlyn*) The original Social Exclusion Unit report really talked about three main reasons, and they were around low expectations in life, that if you have ambition, that you have opportunity, then you are less likely to—

16. I suspect that is the main one, would you say that?

(*Ms Hamlyn*) I think that is the main one, too, and certainly, when we look at the correlation between high rates of teenage pregnancy and the areas concerned, there is a correlation with deprivation, there is a correlation with [2]social class and poverty.

17. Would you expect the more young people who go into higher education that the teenage pregnancy rate would fall?

(*Ms Hamlyn*) Yes, I think that is very much part of our strategy, along with looking at sex education and looking at improving services, it is also about improving opportunities, getting young people back into education, training and employment. There were two other reasons within the Social Exclusion report that were identified, which were around ignorance about knowledge about sex and relationships and contraception, not just about types of contraception but how to use contraception properly and where to get it. And a third area really was the mixed messages of society, that, on the one hand, we find it quite difficult to talk about sex and parents find it quite difficult to talk about it to children; on the other hand,—

18. The British are more buttoned-up about this kind of thing?

(*Ms Hamlyn*) I think, indeed, but a lot to do with our culture, but, on the other hand, young people do get bombarded with quite a lot of sexually-explicit images through the media, so there is quite a conflict in our society. They are the main reasons.

19. There was a 2.4 per cent decrease in the number of teenage pregnancies in 1999–2000?

(*Ms Hamlyn*) It has been over 6 per cent, from 1998 to 2000.

20. That is a fantastic tribute, actually, to your work. Would you put that down to changing educational opportunity?

(*Ms Hamlyn*) I think it will be a combination of factors, a combination of factors of greater emphasis being put on sexual relationships education, improving access for young people to have for services and advice, and of giving attention to reintegration; but it is early days, and we do have quite challenging targets to achieve, but we need to keep on with the programme.

21. On targets, do you have targets for prevention activities, for increasing the availability of advice in schools, or whatever it will be, contraception; have you set a target for that?

(*Ms Hamlyn*) The target that we have been exploring with the Department for Education and Skills has been about improving the accreditation of teachers and specifically it is about improving teaching within schools; that is very much backed up by the recent OFSTED report that talked about that really you would need specialist teachers to have more effective teaching of sex and relationships education. And our intention is to try to reach a point where we have an accredited teacher in each primary and secondary school who will teach sex education.

Andy Burnham: Can I just ask, on this issue of access to sexual health information and services, do you have a concern that faith schools perhaps might not want to implement what you want them to implement, and that you may have a patchwork of different levels of sexual health advice given in schools across the country?

Chairman

22. Does not that happen now, are there not clear distinctions between what schools do?

(*Ms Hamlyn*) There is a requirement for state schools to work within the context of the Department for Education and Skills guidance, but individual schools can take on board, obviously, their own values and ethos, and so on, so faith schools will take on what they think is appropriate in the context of those issues. We are working very closely with a wide range of faith organisations, and, in fact, do have an Inter-Faith Forum that has now been established. Last year, we had three seminars across the country with faith communities, and there will be a resource published later this year, which is about working with diverse communities, with faith communities, so that people on the ground can work effectively. And it is about building relationships and seeing what the common ground is, and I think our experience to date is that there is quite a lot of support for addressing these issues, and it is about finding where we can have the common ground.

Andy Burnham

23. I will finish with one final question. As a result of the strategy introduced, how would you intend to evaluate the extent to which the public have access to both information and services, and how are you collecting the information which shows whether that is increasing or decreasing?

(*Ms Hamlyn*) As a result of the Teenage Pregnancy Strategy, or the Sexual Health Strategy?

24. Sorry, the Sexual Health Strategy, in general?

(*Ms Stanier*) One of our Action Plan commitments is to develop, by next year, a detailed indicator set, which will help to monitor improvements at a local level. We are already exploring indicators, for example, to look at the number of sessions offered in

[2] *Note by witness:* [lower social class].

[**Andy Burnham** *Cont*]
family planning clinics, and we also have a commitment to develop a new indicator around waiting times for GUM services. So I think we are going to need to put into place a whole range of different indicators, looking at the different types of services.

25. Do you have the ability now to say, that part of the country, at that time, is not getting enough, there is not enough access to information and services; are you able to do that on what you now know?
(*Ms Stanier*) I think that our current availability of information is fairly patchy, so, for example, while we have some quite good data, for example, around access to abortion services, I am not sure that we have precisely the type of data around information provision that you are asking about.

Chairman

26. We received some information, just going back to Andy's point about sex education in schools, that where there was a positive sex education programme in the school, there was a clear correlation between a later age of first sex; is that correct, could you sort of spell that out a bit?
(*Ms Hamlyn*) Yes. The evidence shows, and there is research to back this up, that effective sex education does not actually bring forward the age of first sex, it actually serves to delay the age of first sex; and, far from promoting promiscuity, it gives young people more cause to think about the issues, rather than going headlong into sexual relationships. So, yes, the evidence is there to back that up.

27. And you are quite convinced that that is objective and properly researched?
(*Ms Hamlyn*) It is proper research evidence I was quoting from. We can probably come back to you, to give you the quotes on where this one is.

28. I think, because it is so significant, it would be very helpful if you could possibly give us that information?
(*Ms Stanier*) It is Douglas Kirby, the US researcher, and his best review to date, most comprehensive review to date, of evidence on this issue, in the publication "Emerging Answers".

29. But was that research in Britain?
(*Ms Stanier*) It is a review of programmes that have been undertaken in the US. It is also the case though that the Health Education Authority has done a review of research, looking both here and in the US.

30. Right; then that confirms the impression that we got?
(*Ms Stanier*) Exactly.
Chairman: Any information on this would be very welcome for the Committee, thank you.

Sandra Gidley

31. If I can go back a bit, "indicator set" is a dreadful term; is that part-way towards setting targets, towards having indicators, or am I to assume from that that there is no point putting this in place unless you are going to have yet more targets for people to meet?
(*Ms Stanier*) We are not intending to put in place new targets, on the back of the indicators there, it is just really so that we have got better monitoring information, and, I think, for each indicator, we will be quite clear about which direction we would like to see change moving in.

32. I want to go back to the education issues, and, in particular, I think there is a problem with post-16s, and, bearing in mind that most people do become sexually active after that age, coupled with the fact you now have a lot of sixth-form colleges around the country, do you feel that there is a bit of a gap there, where issues are not readily addressed? And this is, I think, and I would welcome your opinion on this, a particular problem when you are talking about young gay men; because, traditionally, schools cannot address gay sex issues, theoretically they can but they all hide behind Section 28. So we now have a situation where, at 16, young men, quite legitimately, can have a gay sex relationship; but it seems to me that outside of London and the metropolitan areas there is not really anywhere that those young men can access for advice as to safe-sex issues and all the rest of it. Has any thought been given to that; because I asked a question of the Department for Education and Employment, as it then was, and they had no plans to change current thinking, which did not fill me with confidence?
(*Ms Stanier*) We have absolutely identified this gap that you talk about, that the personal, social and health education curriculum does not apply to FE colleges, and we actually include within our Implementation Action Plan a commitment to work with DfES, the Department for Education and Skills, to explore what we can do to improve the provision of advice for the further education setting.

33. And what were the timescales for that, because, obviously, each year that it is not addressed we are building up a problem, potentially?
(*Ms Stanier*) I think the Plan gives a deadline of by next year.

34. Right; and, presumably, you cannot predict what will be put in place after that?
(*Ms Stanier*) Not at this stage, no.

35. And how receptive are the Department for Education and Skills to this approach from you?
(*Ms Stanier*) Reasonably receptive; they have agreed to the commitment, and we are already discussing with them how we are going to take forward the first stages of that work.

36. The other thing, with regard to information, it seems to me that very much the strategy is slightly in two halves, you have got the Teenage Pregnancy bit, and you have got the STI bit, and they do not seem to mesh in the middle very easily, in some respects. In reality, how dove-tailed will those two strategies be?

[**Sandra Gidley** *Cont*]

(*Ms Hamlyn*) The Sexual Health Strategy does act as an umbrella, but, yes, the development of the Teenage Pregnancy Programme, Strategy, had already been developed, and so it is the Sexual Health Strategy which provides an umbrella within which the Teenage Pregnancy, as far as the prevention of teenage pregnancy is concerned, actually fits. So, in terms of actually making the links, I think we have made that clear, in terms of making a lot of the links actually within the Action Plan, that certain things need to be developed very much together for the younger age group and the older age group. We can learn the lessons of work that has already been done on the Teenage Pregnancy Programme now for young adults, a lot of the work on improving services, some of this is about mainstream services for both age groups, although for teenage pregnancy we have been encouraging services designated for young people. I think what I do need to point out is, the Teenage Pregnancy Strategy, of course, goes beyond just what you would normally describe as a Sexual Health Strategy, because it does address the fundamental issues of social exclusion for teenage parents, so there is a broader issue than just sexual health that has been dealt with within that programme, so it is quite legitimate that they will develop separately. Yes, there is a coalescence there that needs to happen, in the context of taking forward this strategy.

37. You have just mentioned social exclusion, and certainly my constituency is partly rural, and it would be difficult for people to access services outside of an education system, it is probably more difficult, there is not somewhere that young people can readily go to in a fairly anonymous fashion, if that is what they want to do. So what measures do you hope will be put in place, what is being done to ensure that everybody has access to these services, because there are marked inequalities at the moment, and there are populations such as perhaps ethnic minorities who do not access the services readily?

(*Ms Hamlyn*) I think there are a number of things that are within the Action Plan where we will be putting in good practice guidance, and that includes having a Commissioning Toolkit within which we will be putting good practice guidance around effective contraceptive services, and, indeed, abortion services is another example of that, and the need for those services to properly reflect the interests and the use of a diverse community. So I think that will be reflected in the way that we produce the Commissioning Toolkit, and the advice that will go to PCTs. We also have within the Action Plan a commitment to produce a Health Promotion Toolkit, which again will be about targeting particular groups in a community, practical tips of how you really address those diverse needs. Specifically on the questions of service access, there is already good practice guidance under the Teenage Pregnancy Programme that was developed for young people, and there is specifically guidance for black and ethnic minority communities that we have developed.

38. Has it had any effect?

(*Ms Hamlyn*) It is something that we are monitoring, through the Teenage Pregnancy Programme, through the assessment of the reports that we get back from local areas. We did actually ask, what currently has been in operation has been an audit going on for young people, which has been an audit that has used the criteria in the good practice guidance; we are going to be analysing the results of that audit. The audit is useful for local purposes, but we are receiving at a national level, which will be analysed so we can see what further action needs to be taken.

39. Because we have heard a lot about guidance, and this does worry me, to some extent, because we all have guidance on diet and know what we are supposed to eat, and people rarely do; but, in practice, it is all very well issuing guidance after guidance after guidance, but what measures can actually be taken, practically, to make sure these things are enforced? It seems to me that there is no stick, or no carrot there?

(*Ms Hamlyn*) Clearly, the issues are about the indicator sets that we have to monitor progress, they are about the decisions that are made at a local level, and, in the context of shifting the balance of power, clearly the PCTs now have a very key role to developing sexual health, they need to look at the needs of their local population and what the priorities are, they need to have a cognisance and a regard to the guidance that has been produced; they will be performance-managed by the Strategic Health Authorities in that regard. So where we produce guidance, and indeed standards, the Strategic Health Authorities will be discussing those with the Primary Care Trusts. So I think there are mechanisms through the performance management mechanisms to make some progress in these areas.

Dr Taylor

40. Can I be provocative about prevention, because I think we are losing the battle. When STIs and HIV came into prominence a few years ago, there was tremendous publicity about the risks and the fears, and because the widespread epidemic has not, thank goodness, occurred in this country, people are becoming complacent. I was very sad to hear you say that heterosexual infections now are so often acquired abroad; people know that if you go to the continent of Africa the incidence is tremendous. What are we doing about alerting people, when they go abroad, that they are putting themselves at tremendous risk, if they do have sex, of any sort, really?

(*Dr King*) Can I just say something about the epidemiology there, I am not sure if you have actually got it quite right, or maybe I have misunderstood what you said; but the make-up of the epidemic in this country, in terms of the sort of percent through the various risk groups, is round about 30 per cent in gay and bisexual men, and this is newly-diagnosed HIV infections, and over 50 per cent in heterosexuals, and a small percentage in injecting drug users, and a small percentage in mother to baby. But the point about the heterosexual group is that more than 80 per cent of those infections are infections that, in fact, were transmitted in high-prevalence countries, yes, and predominantly sub-Saharan African countries, but

[**Dr Taylor** *Cont*]
these are also predominantly in newly-arrived people from those countries, so they are from those countries as migrant populations.

41. So it is not vast numbers of tourists going out from here?
(*Dr King*) No; exactly.

42. Well, thank goodness for that.
(*Dr King*) Because I think that was what I had assumed, from what you had said. But we do have health promotion materials, which are very widely available, to alert travellers, who are going to countries of high prevalence of HIV, about the risks of unprotected sex, about the risks of sharing injecting equipment, about the risks of medical or dental interventions, in countries where the infection control procedures are not as good as ours, about the risks of blood transfusion in those countries where they do not screen for blood-borne viruses. I think Kay can probably tell you a little bit more about advice for travellers.
(*Ms Orton*) And, also, the Department funds two leaflets, one on Health Advice for Travellers and one on Travel Safety, which is specifically around the risks of HIV abroad.

43. And you are satisfied that these are being taken note of?
(*Ms Orton*) We like to think so, yes.

Sandra Gidley

44. How do people access these? Only people who are fairly, probably, circumspect would pick these up; is there any will to, I do not know, dish them out with your air tickets?
(*Ms Orton*) The leaflets are available from some travel agents, but it is up to the individual travel agent.

45. But people do not always want to be seen to be picking up one of these leaflets, when their neighbours might be in the travel agent at the same time?
(*Ms Orton*) The Travel Safety that I am talking about, it is designed in such a way that it does not have "Avoid AIDS when you go overseas", it is designed in such a way to avoid that particular issue; it is also available from GP surgeries as well.

Dr Taylor

46. Coming back home, onto the matter really of the distribution of GUM clinics, and the actions of those. Really, we have been terribly disappointed to learn of the delays that patients are going to have in accessing the GUM clinics. In our evidence, I think it is St. George's Hospital, the Courtyard Clinic, "Our walk-in clinics are currently working to full capacity; indeed, our clinics have been unable to operate an open-access service for 18 months." And that where you have an appointments system, people are having to wait days, seven to ten days, for an appointment. And the sort of people, probably, who are wanting to access these clinics, they will sort of forget about it and not care about it. What measures have you got to improve access, what plans, can you aim for a maximum waiting time?
(*Ms Hamlyn*) It is a significant issue. I think I referred to the increase in waiting times, that the average waiting time for a first appointment has lengthened, from five to six days in 2000, to 12 to 14 days; and we know that there is evidence in the country where there will be situations that are worse than that. Now in our Implementation Action Plan, within the monies that we have available this year, we have referred to £6 million for abortion and GUM, the vast majority of that will be for GU clinics, and we are in discussion with the GU speciality about the best way that that can be distributed, targeting the areas where there is the most need, clearly, where there are issues of high case-load, where there is high prevalence, where they are single-handed GU consultants, and where there also has been a record of delivery, which I think is significant for us. I think, if we distribute money to areas which historically have not invested properly in GU services, then we are rewarding really the wrong decisions, although there could be ways in which we could look at matched funding situations. We are also looking at, and it is referred to in the Action Plan, proposing the review of the skill mix within GUM, looking at working practices, skill mix issues, for example, the different use of, whether we are talking about doctors, nurses, HIV and the health advisers actually within GUM. And we will be looking at our overall workforce planning assumptions, in order to be able to improve services, and particularly a robust model is again referred to in the Implementation Plan, about really looking at the impact of waiting times on sexual health outcomes, really modelling that, so we have a very clear answer to that. Clearly, investment, and, as I say, a kind of review of how things are going are key; we can only do so much, in terms of pump-priming monies. I think a key is also going to be the mainstream resources that go, on a day-to-day basis, from the NHS budget into GUM, and, clearly, in any local area where they have those kinds of situations, that is a local decision that really needs to be made in terms of proper investment going in. As I say, we will have some pump-priming money, but PCTs will need to secure adequate investment from their mainstream resources to make the kinds of improvements we are talking about. I have had discussions with the GU speciality, about a concern about really gearing up GUM, before we put additional pressure in terms of uptake, and that is an issue that we have been seriously looking at. It is important that what we can do in terms of pump-priming investment goes out there as soon as possible, so that services can start to gear up to improved services, improved waiting times. We do have a waiting time indicator that we are intending to develop, and that is part of the Action Plan specifically on the question of waiting times. And one of the issues that the GU representatives of the speciality have raised with us is about worries about, if we do a campaign, whether that will increase pressure, and that is something that we are seriously looking at. And, whereas we are reluctant to delay appreciably having a campaign, for all the reasons we have already been talking about, the importance of getting over messages about awareness around sexually-transmitted infections, I think we do recognise the need for gearing up services to be able to cope, and we are looking at that in the context of how any advertising

[Dr Taylor *Cont*]
campaign will be rolled out, the timing of some of that, in the context of how we can gear up and ensure that GUM are properly geared up, in terms of improving their current position, actually, on those issues.

47. Can I clarify, is this £6 million recurring, or just a one-off?

(*Ms Hamlyn*) I am talking about pump-priming money for this year. As we have indicated in our Action Plan, in terms of funding for subsequent years, that is subject to overall decisions that need to be made in the outcome of the Spending Review, at the present time, so we cannot confirm what will happen beyond this year. Clearly, there is the broader issue, that the NHS is getting an increase in overall resources, in terms of mainstream resources, which is there to improve all services, that includes improving where there is a dire need to improve GUM; and, again, that is down to the local decisions to be made.

48. But really it is going to be up to PCTs to insist on getting an extra GU consultant in their area?

(*Ms Hamlyn*) I think that the whole emphasis of our approach to the Health Service in general is about local decision-making, local priorities, so a key issue is about PCTs looking at those kinds of problems in their area and then doing something about them.

49. But there is not a lump of extra money coming in automatically to get extra consultants in GUM?

(*Ms Hamlyn*) There is a lump of money coming in, as I say, this year; as I said, whether there will be any further money available for GUM has to be subject to exactly how much that might be, coming from the centre, as a specific allocation, will have to be subject to decisions about the overall outcome of the Spending Review settlement.

Chairman: Could I just ask, on the pressure on GUM clinics, has any thought been given to how we might make better use of primary care facilities? I appreciate, obviously, that many people would not wish to, because of the stigma, etc., go to their own GP, but, have I stolen your question? I am sorry, I will get you upset with me now.

Dr Naysmith: No, no.

Chairman

50. I meant stigma, actually to their own GP for this particular issue. It just struck me that there are ways and means possibly of making better use of the opportunities we have now with PCTs; is that impractical, the reasons why specifically people have to see a consultant? I would have thought, from my limited knowledge of this area, that it may be we could look at that issue; is it something that you have thought of?

(*Ms Hamlyn*) I think we are looking at a number of different models, we are looking in a strategy within the framework for the model services, we talk about a Level One, Level Two, Level Three service. Level One refers to what would be available in any local area, whether that is through GUM facilities or through general practice, that we want to see HIV and STI testing, for example, actually provided at that kind of local level, but more specialist services provided, and we refer to Level Two and Level Three. We are not talking about doing everything in primary care, but primary care, undoubtedly, and GP practice, have a role to play in this. And, as I said, I think it is something that we need to develop over time, general practice may feel already that they have got a lot of other priorities and pressures on them too; so I think it is something that we will be working on with the Royal of College of GPs, and will be developing over time. We can look at different settings; we also have in the strategy the idea of piloting One Stop Shops, where you go for your contraception and you get the potential to be tested, STI-tested, and so on, so there are different models that we can look at, that it is not just one size fits all, and, of course, different models may be appropriate for different communities.

Dr Naysmith

51. It is an area I wanted to explore, this question of primary care and the stigma that does apply, in some cases, and the Chairman has already referred to that. But is there a willingness on behalf of general practitioners, in general, to get engaged in this sort of medicine, do they want to expand it, really, was what I wanted to know?

(*Ms Hamlyn*) I think it varies. I think there will be the enthusiasts, who—

52. This is why you want to talk to the College?

(*Ms Hamlyn*) The College, and indeed some of the people within their specific task force, are looking at some of these issues within the College. There will be enthusiasts who really want to ensure that this actually is developed further within general practice; and during consultation we heard of some parts of the country where general practice really wanted to develop not just Level One but Level Two, for the majority of practices in Essex, this was one example where the majority of practices were suggesting they wanted to do Level Two. So it will vary across the country, and I think we do recognise it is a long-term plan we need here, to look at, discuss with the profession, PCTs need to explore it locally. I think the importance is though, at any local level, about giving a choice of services; and this is, indeed, what people were saying to us, through the consultation, that they do not want to feel that going to general practice is a serious thing, any more than they want to feel that GUM, and people feel differently about the stigma attached to both of those; some will go to general practice and feel that is the best for them, some will not want to go to GUM, and vice versa. I think it does vary, and we want to ensure that there is that choice, so that is available to people.

53. It raises some interesting questions though, in general, because we are moving to a system of diagnostic and treatment centres, at least in theory, in some parts of the country, which will involve consultants coming out from regional centres or district hospitals and operating, operating in the sense of working, much more in the community. And GUM clinics tend to be located in, in my experience, well, in Bristol, the one that I know best, it is in a prefab at the back of the BRI, and maybe that is partly to avoid the kind of stigma, that gives them a

[**Dr Naysmith** *Cont*]
chance to move these things out much more into the clinic, using the move towards diagnostic and treatment centres?

(*Ms Hamlyn*) I think we can take that and look at that as an opportunity. I have said that we want to test the kind of One Stop Shop model. There are examples round the country where you have got a family planning clinic that are looking certainly to chlamydia screening, and are looking to see what else they could do on STI testing and screening. Size constraints are about whether you have got laboratories on easy access, about some of the models, but I think these are all things that we can explore and look to see how we can improve access over time.

54. And how would the resources be worked out there?

(*Ms Hamlyn*) As I said, we have a commitment, with the strategy, for £47½ million for the strategy, but that can only be pump-priming money; the main source of money for developing the service in this way will have to come from the NHS budget, for which, of course, they have had a higher settlement of money.

Dr Taylor

55. May I just come back, because our advisers have picked up a point, very astutely. If we take a large city, like this one, obviously, large numbers of the attendees coming to GUM clinics come from outside the area, so they are not actually under the PCT that is responsible for that area; so the new posts have got to be based on local needs, because these patients may not be of that PCT. How can you take that into account?

(*Ms Hamlyn*) The arrangements that previously applied, and which we are encouraging to continue, are where PCTs work in collaboration, and this is particularly important for London, there has been a London commissioning group, specifically looking at HIV issues, there has been one in the North West as well, and it is where they work in concert together. And, indeed, in some cases, where you may get one PCT acting on behalf of a number of other PCTs, to look at the issue and really to combine available resources to develop local services, it is within their commissioning role that I am particularly talking about, although there are also examples round the country where one PCT has acted on behalf of the others in respect of provision of sexual health services more generally as well.

56. That is actually happening in my own county, where one PCT has taken on the responsibility for sexual health. Now will the established NSFs, in things like diabetes and heart disease, take money away from sexual health?

(*Ms Hamlyn*) I would say that there is an opportunity through those, and perhaps Ruth could say a bit about those particular National Service Frameworks.

(*Ms Stanier*) While there is not a specific NSF for this particular area that we are talking about today, we are trying to make sure that we get appropriate cross-references into National Service Frameworks that are being developed. For example, diabetes, the Diabetes NSF does include references to sexual health, and we are similarly working to make sure that the Children's NSF and the forthcoming Long-Term Conditions NSF do the same. In terms of whether the NSFs will take funding away from the Sexual Health Strategy, I think it is more the context that Cathy has already outlined, that there are significant additional resources going into the NHS, both to implement the NSFs but also to improve quality right across the board.

Julia Drown

57. First of all, I want to go back to the issue about resources, clearly, all sorts of discussions are taking place, in terms of the Comprehensive Spending Review, but, given the quite alarming increases in infections and the untapped and undealt with problems that are clearly out there, the increases one might expect to see within departments even start dwarfing the considerable amount of money that has already been identified for the NHS. Do you have in your mind, can you tell the Committee, the sort of increase in resources you think that departments would need, over the intermediate term, looking, say, five years ahead?

(*Ms Stanier*) Are you talking specifically about GUM departments, was that your question?

58. Yes.

(*Ms Stanier*) We have not done any specific projections that we have published ourselves. We are in touch with the speciality, and they have provided some projections.

59. What do they think is needed?

(*Ms Hamlyn*) The projections that they have shown us are that, in order to bring the current waiting times down to deal with the immediate shortfall would require in a full year £7½ million. I did say earlier that the majority of the £6 million was going this year, and we will be issuing really just for half a year, so it ought to make an appreciable difference this year actually in terms of addressing some of the waiting time. I mentioned earlier though the issue that they have been worried about the impact of any campaign; they have done some projections, in their opinion, about what impact a campaign will have. I have to say that we take a slightly different view about what the impact of a campaign might be, and it is probably too early to say, but some of what they were drawing on was some experience in terms of a campaign in Wales, where the information we have had is that that has not brought about large increases in the worried well, if you like, going to clinics. And the impact of where we have had campaigns already, we have had some campaigning going on already, but that again has not resulted in large increases of people, again, the worried well, turning up to clinics. So clearly this is something that we will need to keep close attention to, in terms of the impact of the campaign; the campaign is not primarily about directing people to services, it will raise awareness, but it is about promoting condom use. But, yes, I accept that there will be some people who will think, well, maybe they ought to get tested. I think the question is whether that means that they are rushed to go to do so, I

[**Julia Drown** *Cont*]
think, is still a question-mark that we clearly need to keep under review. I think that was why I referred earlier to, as a result of our discussions with the GU speciality, I think we are recognising that we need to make certain that the speciality GUM clinics can cope, if there was an increase in workload, and where we will time the roll-out of any campaign accordingly. And we are talking about, potentially, although we were talking about launching, announcing the campaign in the autumn, the potential roll-out would be after Christmas, and we will pace that accordingly, to allow the additional investment that have I talked about to really take impact.

60. Would you be able to supply the Committee with those sort of two sides of the debate, both what the clinics are reporting and what is needed, and what they think would happen as a result of a campaign, and then the Department of Health knowledge, given the Welsh situation?
(*Ms Hamlyn*) Yes, we can do that.

61. You said to Richard earlier about, if there was an increasing need, say, for a consultant, how it would be up to the PCTs to look at that and employ extra consultants; but what about training new consultants for the future, what sort of input are you making into how many we are training for the future?
(*Ms Stanier*) We are working closely with our colleagues who work on workforce projections within the Department. Part of our Action Plan is a commitment to do a better review of the workforce implications of the strategy. We have estimated that there should be an additional 35 consultants who have come through the training system by 2004, and then a further 25 by 2009. We are aware that the speciality are estimating that roughly 70 consultants are currently coming through the training system, but we need to offset those estimates against how many are likely to retire, over this time period.

62. It sounds like small numbers, particularly since a lot of consultants are just working on their own, so if you just take one, either to retire or go and do something else, and you have no department, in terms of consultant time; how much is that a concern to the Department?
(*Ms Stanier*) It is certainly a concern, and, as I say, we have committed to reviewing those projections and to working with the speciality to make sure that the projections are as good as they can be. But I think, as Cathy said earlier, improving GUM services is not just about new consultants, yes, we do need new consultants, but it is also about looking at the overall skill mix.

63. Just going back, I have just been given some more information here; you said, about the GUM consultants, thinking we would need £7.5 million for pump-priming the service, was not that figure actually £14 million?
(*Ms Hamlyn*) There was £14 million quoted in the paper; the actual schedule that they showed us, in terms of actually looking at the impact on reducing waiting times showed £7½ million, and, as I say, they then did a further projection of another £9 million on the impact of the campaign, and it is the latter bit which, (which actually is £16 million, is it not) the latter bit which, as I say, we have a slightly different view about what really the impact of the campaign will be.
(*Ms Stanier*) I think that we are talking about two separate papers that have been provided by the speciality.[3] One was looking at a range of pump-priming measures, which totalled £14 million, and then there was a separate paper looking at how we could address the immediate capacity issues and the impact of the campaign.

Dr Taylor

64. So where is the £6 million you were talking about?
(*Ms Hamlyn*) The £6 million is the money that we are making available this year proportional to each area. I have said that the vast majority of that will be for GUM, as I said, that is available this year; that, given where we are, we are now in June, and we need some discussions with the speciality about exactly how we distribute it. That is the money available, effectively, to improve things for the rest of the year.

Julia Drown

65. But the projection is another £9 million after that, is that right?
(*Ms Hamlyn*) The speciality were arguing that, over and above, they suggested that we needed £7½ million in a full year; what I am suggesting is £5 million will go a long way to addressing the immediate issues of the waiting time.

66. Six; you just said five?
(*Ms Hamlyn*) I am estimating that five, sorry, I am confusing you, I am estimating that probably about £5 million of the six[4] will be probably what we will end up doing GUM, but that is, if you like, a working figure, because we will obviously need to discuss it further. And I am suggesting that that actually will go a long way, given that we are only talking about half a year, towards the kind of projection that the speciality are making to address the immediate shortfall. Then there is the question about what impact the campaign will have, and, as I said, the speciality did do some projections about that, that we can let you have, and that is probably the easiest way to clarify any confusion on this, for which, as I say, we have a slightly different view.

67. Sure; and, in terms of the Welsh campaign you mentioned, would you accept that the campaign there did increase the waiting time at clinics from three to six weeks, the waiting time at clinics?
(*Ms Orton*) We understand, from our colleagues in the Welsh Assembly, that the complete data is not yet available, so it may be that there is some important data that we have not received, or seen the complete data on that.

68. I want to go on to talk a bit about chlamydia screening, and the pilots that have been done have shown very high infection, around 10 per cent; and in your evidence you talk about, or in the Action Plan,

[3] *Note by witness:* We will submit both papers to the Committee with our additional evidence.
[4] *Note by witness:* £1 million is for abortion services.

[**Julia Drown** *Cont*]
it talks about the national screening programme will start to be introduced in ten sites, selected from those areas which have expressed an interest. Given this is a condition which can be relatively easily treated, and does have serious consequences, should we not be doing much more on that?

(*Ms Hamlyn*) I think that there are a number of issues around this, the pilots were very useful, the two pilots in the Wirrall and Portsmouth, to really test both, yes, as you referred to, it showed actually in terms of what the results, of high levels it was showing. One of the reasons we wanted to have the pilots was to test the acceptability of the method and the model, and urine testing was the method and was regarded as acceptable to women. There are issues that have been raised about, this was mainly around women, although men were included in the screening; we are going for an opportunistic screening programme that is primarily focused on women, but again we want to look at the issues around men, and men have, again, one of the increasing rates. In other issues, what we do not know at present, and we have a study going on, is actually whether there is a need to recall; if all that happens is a woman gets reinfected again, we do not know how quickly we should actually then call them back for screening, so there is a reinfection study going on, and that will therefore inform our further roll-out. I think probably the third thing to say is that we really need to build the capacity, and training needs to be there, to roll out, and we cannot do that in five minutes, there really needs to be a programme in order to do that across the country. So it is reasonable, I think, at this stage, for us to be rolling out just to ten sites and then being reinformed by practice in those sites, being reinformed by the infection study, and being able to build the capacity and the training of people right across the country.

69. So when is there to be a plan for a proper national screening service, and I say it particularly because I am aware that if there is a reinfection the population could become resistant to antibiotics, and then the problem gets more complicated? Should this not be a thing like the sort of polio programmes in developing countries, where we say that we, as a nation, are going to try to get rid of this major problem that is so easily treatable? When will we be in a position to be able to have that sort of national screening, to eradicate what is often a hidden but very difficult condition?

(*Ms Hamlyn*) We do not have a date for full roll-out, as yet, and clearly that is something we need to come back to, in the context of being informed by the ten areas and, indeed, the reinfection study, but we do not have an end date to launch.

Dr Naysmith

70. Could we just explore that a little bit more, about the reinfection; why is that so much of a problem and why have you got a special study looking at it?

(*Ms Hamlyn*) It is about really thinking about how quickly someone gets reinfected, and therefore whether we ought to build in, as you do in other screening programmes, a recall system, and how that recall system should actually work, bearing in mind that we are talking about opportunistic screening here. So I think we do need to look at that, to look at the various approaches.

71. Is there a suggestion that people are going back to partners and getting reinfected, and therefore what you are talking about is a much bigger problem, in order to do what Julia wants, to try to eliminate it? As well as treating people who present with the symptoms, you have then got to go and seek out all regular partners and then sort that out before there is any point in doing a big screening programme?

(*Dr King*) I was just going to make an observation, that, in fact, we have talked already about Natsal and we have talked about the difference in sexual behaviour that has occurred over the last ten years, and those are the sort of two snapshots that we have got of sexual behaviour, and Cathy has explained the differences in those; and one of the differences is the increase in the number of sexual partners. And, clearly, if you are having unprotected sex with a number of sexual partners and those partners are changing, you may, in fact, have chlamydia treated and then be reinfected by another partner.

Dr Naysmith: That is the point I am making, in suggesting that, in order to have a kind of viable screening programme, and then treatment programme, it could lead you into a vast kind of really expensive way of sorting out the situation; and it might be the right thing to do.

Julia Drown: I would like to add another question to that, because is there any work done on whether it is actually more cost-effective not to rely on an opportunistic programme, on which you would get individuals coming in and turning up for other things, and offering screening then, but to have one large national programme, all concentrated around a particular time, which then gets over much of the stigma and all the other associated problems with this, but to say, "We are going to have this national scheme and we want everybody to come forward who has any slight possibility of being infected, because we want to get this out of the population; you're doing it not only for yourself but you're doing it for the wider population"? I would have thought there was a real possibility that that actually might be more cost-effective than trying to just pick up people who are turning up at clinics?

Chairman: But the point is, you could not handle that?

Julia Drown

72. You could not now, but you could build up to do that?

(*Ms Hamlyn*) There is an issue about cost-effectiveness here as well. The original model that was being piloted was based on work by an expert committee, involving the Chief Medical Officer; that looked at an economic model of whether this would be an effective way of doing it, an acceptable way of doing it, but also whether it was cost-effective to introduce screening in that particular way. So there is an issue about cost, clearly, in what you are describing.

73. So it has been ruled out, to be less cost-effective?

[**Julia Drown** *Cont*]

(*Ms Hamlyn*) What the model looked at is, the particular one currently was one that was explored through the expert committee. I think it would be a matter for you perhaps taking some further evidence from that committee, if you wanted to explore that further.

Dr Naysmith

74. We would be interested to find out more about the programme, the reinfection programme?

(*Ms Duncan*) I was just going to say that the pilots in the Wirrall and Portsmouth did actually achieve quite significant levels of population coverage, for example, 50 per cent in Portsmouth and 38 per cent in the Wirral; so they were successful in terms of the population they were trying to get at.

Chairman

75. Could I ask a question about what evidence you have of STIs being picked up through routine screening or attendance at, say, contraception clinic, or cervical smears, or whatever; do you have any sort of figures that indicate the proportion of STIs that were picked up through some form of health intervention where a person went to a clinic for something else?

(*Ms Hamlyn*) I will ask my colleagues whether we have got any information to hand.

(*Ms Stanier*) I am not aware that we have any information on that.

(*Dr King*) We have a surveillance system, from every GUM clinic in the country, which has contributed.

76. I was thinking more further down the line, where a person who had not been aware, maybe, that they had got chlamydia, or whatever, and a cervical smear would pick up that fact, whether we keep any record of the proportion of STIs that are picked up through that kind of routine screening?

(*Ms Stanier*) I am not aware that we do.

77. But it is possible to do that, presumably, is it?

(*Dr King*) We are looking to improve surveillance of STIs in GUM clinics, as part of implementation of the Sexual Health and HIV Strategy, and clearly that national collection system, which comes from every GUM clinic, it could be one of the factors that is looked at. But the more complex your data is, in any of these collection systems, then the more difficult it is for the clinicians at the GUM clinic and others that are actually providing it, so it would need to be carefully looked at, what type of question you were asking.

78. The point I was making would be that, presumably, it is conceivable for a woman who was attending a family planning clinic to be examined, and the doctor there to notice that she had some particular problem, and steps could be taken accordingly to treat that particular problem. What that brings me on to asking about is the fact that, certainly as I see it, the screening process of that nature, where the problems that are picked up are more likely to involve women than men, therefore what are your thoughts on how we may engage more with the male population in respect of picking up and addressing this particular problem?

(*Dr King*) It is a difficult one, is it not, really.

79. You need to come back to me then. Only I am conscious that we have, interestingly, an all-female panel of witnesses; as a male, I feel that I want to ask that question, because certainly the figures we have got indicate that men have problems as well, and may well be assisting the reinfection problems?

(*Ms Stanier*) One thing that we have done already, as part of the Teenage Pregnancy Strategy, is to issue best practice guidance about contraceptive services for young men and to try to make young people contraceptive services more welcoming to young men, for example, by having specialist young men sessions; so we have started to look at one part of this area.

80. Would you accept that the fact that we frequently fail to address male health as a wider issue has a bearing on the problems that you are addressing here; and do you have any thoughts within your strategy on how we might be much more vigorous about engaging with men? And if it is possible to test on the basis of a urine sample, how we might sort of simplify, rather than kind of having, I can recall, in my youth, hearing all sorts of lurid tales about what happened if you got it, and the kind of tests involved, that actually some of these tests are quite simple, and it may be helpful for people to actually have these in a routine way. Is that an area that you have given any thought to?

(*Ms Hamlyn*) It was very well highlighted during the consultation, the issue of men, particularly men and chlamydia, and the need to look at different ways that men can actually access support and services. We want to learn from other places, such as in Scotland, they have been looking at postal systems for testing, and so there are some other examples where we want to explore that further. And, yes, I totally agree that there is a broader issue about men's health. And there is some developing work to really look at some of the broader issues around men's health, and within which sexual health clearly needs to play a part.

Dr Naysmith

81. We have talked quite a lot about resources already, but I did want to look at HIV, because of the changes that have taken place, that it is now firmly back in the mainstream, after having been specially funded for a while. Is it quite clear that the responsibilities are, in terms of funding, between Primary Care Trusts, Strategic Health Authorities and specialist commissioners, is it clear and transparent who should be funding what? It is HIV I am talking about, because of the way it has been changed, in terms of its treatment, over the last few years?

(*Ms Hamlyn*) The key issue now is that PCTs have now received, within their overall allocations, an element that is associated, what previously would have been separate, in terms of ring-fenced allocation for HIV treatment and prevention; so PCTs have the key responsibility, in terms of commissioning. But

[**Dr Naysmith** *Cont*]
some of the arrangements, there is a transitional period where there is an arrangement for joint commissioning of treatment, particularly in the context of some of the points that were raised earlier, where you are talking about treatment providers who provide a service to a wide range of areas, it is the importance of those commissioners coming together. So the intention is that there will continue to be some of those collaborative arrangements; so we are in a transitional period, where some of that expertise will develop through Strategic Health Authorities, as now, previously health authorities, playing some part in working with PCTs in that transition, and, clearly, where we are also encouraging the continuation of those joint commissioning arrangements. But PCTs very clearly have the responsibility in terms of looking at their local populations, as I mentioned earlier, their needs, in terms of HIV prevention and sexual health contraceptive services, it is very clearly with them. I think the issues I was talking about were broadly around the way that treatment needs would be commissioned, because of the issue that it is a specialist service.

82. Really what I am getting at is, there has been some suggestion that some monies have been lost in the sort of transfer in; are you happy to say that it is quite clear now who should be commissioning what, which services, treatment and preventative?

(*Ms Hamlyn*) I think it is quite clear, but it is an issue that a lot of concern was raised on this issue during the consultation period, and people were worried about what impact it might have, that it would no longer be ring-fenced, and what impact it might have particularly on the voluntary sector. In our Implementation Action Plan, we have said very firmly that we will be monitoring investment through the performance management mechanisms that we have, through the Service and Financial Framework that we have, to look at investment in HIV.

83. So what will the monitoring look like, how are you going to do that?

(*Ms Hamlyn*) Through this Service and Financial Framework, individual PCTs will be required to say what their investment plans are and what they have spent; we also have the mechanism, through the AIDS Control Act, where they are required to report, and we will be reviewing the AIDS Control Act data requirements, as part of the Action Plan. And we have, in fact, surveyed recently and followed up on a sample to look at plans on investment, and the majority, certainly from that survey that we have done, to date, and we will have fuller information in August, suggests that investment levels have been maintained, the majority, if not increased, in some cases.

84. Is this, in effect, ring-fenced money then?

(*Ms Hamlyn*) It is not ring-fenced any more, no; that was the major change that happened.

85. So it will depend on your monitoring deciding whether or not the same amount of money is being spent?

(*Ms Hamlyn*) The decisions are dependent on the local area; but we will be monitoring the impact, that was what I was referring to, the monitoring mechanisms. Strategic Health Authorities will take up the issues with individual PCTs, and ultimately the Department can step in, if there really is an issue. I was just going to mention the voluntary sector, because that was a particular worry that was raised with us; and, again, we will be, through the voluntary national organisations that we work with, asking for their feedback on where perhaps that is impacting in a negative way, if that is what happens, on particular voluntary sector organisations. So we are setting up a number of different mechanisms to monitor the impact of the decision on mainstreaming.

Sandra Gidley

86. Can I just clarify something, which I am not quite sure of the situation. Currently, presumably, areas like London and Brighton receive large amounts of money; will that continue in the future? Because there are some parts of the country where the prevalence is extremely low, and other parts of the country where the prevalence of HIV is extremely high, and, very often, those areas need more spent on public awareness campaigns, targeted or otherwise, as well as the treatment; so it seems unfair if everything is going to go into the pot, and those areas with a high incidence do not receive some sort of extra funding. So how will that be monitored?

(*Ms Stanier*) The arrangements that were made for mainstreaming meant that, for this year's allocations, an amount of money for each area, dependent on their HIV prevalence, was put into the overall mainstream pot, and it will continue to be the case into the future, that there will be, if you like, a hidden line within the mainstream allocations, so those allocations will continue to reflect HIV prevalence in particular areas.

87. But the spend will then be monitored to see, how is that audited, in effect?

(*Ms Stanier*) As Cathy has explained, we will be monitoring spend. I think, increasingly, looking into the future, we are going to be looking more at how the rates are moving, and comparing that against the particular interventions that local areas are making.

88. Right; and if patients travel outside their PCT, which can be some distance, because there are areas where there is good treatment, but people may move from an area where there is a low prevalence to an area where there is a high prevalence to obtain specialist treatment, how do the PCTs providing that patient's care get their money back? It sounds as though potentially it could be quite bureaucratic?

(*Ms Stanier*) There has been an arrangement in place between health authorities for such recharging to take place; and we are developing the Commissioning Toolkit, that we refer to in the Action Plan, and we are going to be providing further guidance within that Toolkit on how these recharging arrangements need to continue.

89. So you cannot really say at the moment, is that right; all these toolkits and guidelines are all very well, but it does not exactly help us to gain a clear picture of what is going on?

(*Ms Stanier*) It is very complex, and members of our team are currently talking with the profession to make sure that we get the guidance that we do give right; though we do not have a definitive answer.

[**Sandra Gidley** *Cont*]

90. So the fact that people need to, because people do not want to be in a position where they are denied funding, because this falls down. I think actually it is quite important, if we are providing the service?

(*Ms Stanier*) It is very important, and it will be sorted out during the current financial year.

91. Right; so you have to wait and see?

(*Ms Stanier*) I think that is what I have explained, yes.

John Austin

92. Is there a danger that we have got a sort of deserving and undeserving poor sort of scenario, that the Terrence Higgins Trust has sort of made a comment that there may be a deprioritisation of stigmatised groups, such as gay men, in favour of, say, young people, and that the whole resource allocation may be skewed by local commissioning? Do you think your monitoring is going to be adequate to pick that up, and do you think that the fears of the Terrence Higgins Trust are misplaced?

(*Ms Hamlyn*) I think this comes back to the way that we actually look to the requirements through the AIDS Control Act, and we can ask for information down to particular groups. But I think that what I would say is that we have a full commitment, in terms of our national resources, we already put, and Kay can comment further, a significant amount of money through the Terrence Higgins Trust for national programmes, through the CHAPS, the Community HIV Strategy, for national initiatives around sexual health promotion with gay men. So there is a commitment at national level to continue with that. Do you want to comment further on that?

(*Ms Orton*) Yes. For a number of years, we commissioned the Terrence Higgins Trust for the CHAPS Initiative and plan to continue; we are currently funding £1.1 million, and that is a national initiative which we want to continue. We also fund the voluntary sector, through something called the Section 64 support scheme, and we fund over £1 million on HIV/AIDS and sexual health.

93. That is at sort of global and national levels; and, in terms of local commissioning practices, do you think your monitoring processes will be sufficient?

(*Ms Hamlyn*) I think it does come back to the other guidance that we give, that Ruth was referring to earlier, that the kind of priority groups, which were set out in the strategy, will continue to be gay men, yes, young people is clearly another one; in fact, we had a huge number of targeted groups that people thought we ought to be addressing. But we will be addressing some of those through the Commissioning Toolkit, through the guidance we give to PCTs, in terms of commissioning practice, but at the end of the day it will be PCTs to look to the local priorities in their area, and I do not think you can get away from that issue, that we are talking about local decision-making here, based on local population needs.

Dr Taylor

94. I think we have had a lot on resources and manpower. Specifically to Ms Orton, are there are any specific promotion campaigns that you are about to launch?

(*Ms Orton*) The main one is the campaign that we mentioned in the strategy, the Information Campaign for Young Adults, and we are currently working with the design agency on developing that, and that has been informed by a review of the research on what sorts of messages and campaigns work best for this target group. So that we are planning to launch that, and, as Cathy mentioned, in the autumn, but the launch may well be phased to take account of pressures that we have already discussed on GUM.

95. So we can look forward to that sometime in the autumn?

(*Ms Orton*) Yes.

96. Is there an official strategy about HIV testing, who should be tested, when they should be tested, right at the beginning?

(*Dr King*) Yes, the strategy has a goal about HIV testing, and this really is one of the issues that came up during the development of the strategy, and that is, in this country, we have, the current prevalence, I think, is 33,500 HIV-infected people; now approximately a third of those are unaware of their infection, and so one of the aims of the strategy is to decrease that undiagnosed pool, so that people can be aware of their infection and receive advice about preventing onward transmission, but importantly receive advice about their own treatment and care. So that is a goal, and in order to achieve that goal we have set a standard that all people coming to a GUM clinic for an STI screen should be offered an HIV test. This was informed by an expert group that was set up, that included GUM physicians, and their observations, and the evidence that some people were leaving GUM clinics with HIV infection and still unaware of their infection, so it was not being picked up because they were not actively being offered an HIV test. And, in order to track how we are doing against this goal, we have set a number of aims, in terms of uptake of the test, and decreasing the numbers of undiagnosed infections, in that group. But we have to bear in mind always that this is an offer of a test, and it is not a mandatory test, and people have the right to refuse that test.

97. Have you any idea of the sort of uptake?

(*Dr King*) The GUM physicians that were helping us in formulating this, they had some evidence from their own clinics, and they felt that 30 per cent uptake at that time was the sort of uptake that they were getting, so we were putting it at 40 and now 60.[5]

[5] *Note by witness:* The aim of the Implementation action plan is to reduce the prevalence of undiagnosed HIV and STIs—in particular, by setting a national standard that all GUM services should offer an HIV test to clinic attendees on their first screening for STIs, and working towards shorter waiting times for urgent appointments in GUM services.

Dr Naysmith

98. This is slightly unrelated to what has been said, but since I have Dr King here I would like to ask the question. I met an asylum-seeker this morning, a lady, who had a pregnancy while in this country, and she was HIV positive, and she had tremendous trouble accessing milk, either tokens or milk substitute, because, of course, she did not want to feed her new-born child. Is there any kind of programme to assist, because she was in emergency accommodation when all this happened, and was unable to access benefits properly; and this obviously happens occasionally, more than occasionally?

(*Dr King*) Yes; as you are probably aware, it is the Department's guidance that, in fact, HIV-infected pregnant women, should be advised that one of the interventions, to prevent transmission to their children, is the advice that they do not breast-feed; and in this country, where there is access to formula milk and to clean preparations, that advice stands and it is supported by WHO and UNAIDS advice. There is an issue that we know about, which is the one that you have outlined, and that is asylum-seekers and the cost of formula milk; and we are in discussion with the Home Office, and I believe there is a judicial review at the moment currently looking at the provision of welfare foods, because formula milk would come under that, and the regulations about welfare foods and asylum regulations as well.

99. It would, of course, be one of the most cost-efficient measures you can do, is to prevent the child from becoming HIV-infected, just by providing some milk substitute?

(*Dr King*) Yes. I am aware that there are some local trusts, and also most[6] of our health authorities, that in fact did set up schemes, and one not very far from here, in Lambeth, Southwark and Lewisham, providing the sterilising equipment and the formula milk to their HIV-infected—

100. So this is something that is on the Department's agenda and is being addressed, is it?

(*Dr King*) It is on the agenda, yes, and we are looking to find a way round it, it is quite complex but we are in discussion with the Home Office as well about it.

Mr Burns

101. I thought if I could just go back to the whole question of awareness, which I know two of my colleagues have raised with you, fairly briefly. If one looks at your memorandum, that we got sent in advance, it was interesting to see in one part of one of your documents, saying that there were substantial decreases in the incidence of STIs throughout the 1980s, but in the last decade there has been a dramatic rise in diagnosis. One also sees, in another of your memoranda, saying, "In 1999 most people questioned in a national study did not know what chlamydia was." It also said that two surveys done by the National Survey of Sexual Attitudes and Lifestyles in 1990 and 2000, show that, in the second one, "there had been an increase in behaviours associated with increased risk of HIV and STI transmission, including increases in numbers of partners," and, "in particular, there were considerably higher rates of new partner acquisition Among those younger than 25 years and this is reflected in the substantially higher incidence of STIs in this age group." As you will be aware, there was, which I think was for the first time ever, a very high profile awareness campaign through television, through cinema, in the mid 1980s, which I think one of you said earlier in this session did have an impact which helped make sure that we were not, as a nation, on the back foot for the next decade or so. We have not had that sort of high profile awareness campaign, I think, to the best of my knowledge, for the last ten years, and yet the evidence you are providing us with suggests that, after, presumably, an impact of that awareness campaign, people got lulled into complacency, a false sense of security, or whatever, and, of course, a new generation has grown up that will be totally unaware of that. Your strategy plan that you made available to us has the national information campaign, and you have said that it will start this autumn, possibly in a staggered way. What I am interested to know is how exactly do you envisage that is going to work? Are you, because of the evidence and the facts and figures of diagnosis, going to have any very high profile campaigns to really bring the message home to everybody, as well as, presumably, specialist awareness campaigns, in targeted, presumably, publications, targeted areas, like GP surgeries, or whatever, or what are you going to do? Is it going to be a big bang approach, or is it going to be a lot of different, more lower profile but more carefully targeted campaigns, or a combination of both?

(*Ms Hamlyn*) I think it is a combination of both; and I would probably say a medium bang campaign, really. We are talking about the need for a sustained campaign. Some of the dangers of having a big bang approach is that you have big bang and then you stop; we want a sustained approach over a period of time. We have also learned our lessons from some of those previous campaigns, and, indeed, have done some quite thorough research about the current, and particularly the 18-30 age group, which is really kind of two groups, as you quite rightly say, it is 18 to early 20s, and particularly the issues of changing partners; for later, it is usually the people settling down, and there can equally be some issues in terms of sexual health at that particular point. And it is that group that we are particularly talking about focusing on, but as a mass advertising campaign, but appropriately targeted in media that actually will be seen and appeal to that particular age group, the 18-30 age group. But the age group under 18, we are already targeting through the Teenage Pregnancy Programme, again, in appropriate media; that includes using magazines, looking at radio, potentially cinema, looking at ambient materials, we are talking about an advertising campaign here and being quite imaginative about how we can use public relations more generally, associated with that. The reason I referred to learning some of the lessons is that this particular, the young population we are talking about now, the kind of approach of the kind

[6] *Note by witness:* In retrospect, we are only aware of a limited number of schemes.

[**Mr Burns** *Cont*]
of fear-based campaigns is not going to work, nor will young people today appreciate being lectured at, I think, from my evidence.

Mr Burns: Sorry, can I just be clear that I heard you properly. Before you got on to the point about lecturing—

Chairman: Order. We have a division in the Commons, so we will adjourn for exactly ten minutes.

The Committee suspended from 5.50 pm to 6 pm for a division in the House

Chairman: Colleagues, I think we are quorate, so can we resume.

Mr Burns

102. You were in the middle of answering, before we were so rudely interrupted?

(*Ms Hamlyn*) You raised the question about, and I referred to, that we have learned some issues around, and people raise this because they are worried that we might do a replica of the Tombstone campaign; now it had its day, but I think some of the issues about doing a kind of fear-based campaign like that is that, if the threat, and the threat then was presented as an issue both for the gay community and the heterosexual community, if the threat does not bring out the same, to the realities of heterosexuals, as indeed has happened in this country, then people start to distance themselves from the issue. And, clearly, the evidence that we have had from our research from the preamble to our campaign is that people lived through that, and the heterosexual community therefore do not see HIV as a threat, and indeed they do not see it as a risk, but nor do they see it as, are not fully aware of sexually-transmitted infections in general. So our campaign needs to, certainly all the evidence is that fear, for the current generation, that fear-based campaigns are not effective, that what we need to do is a sustained campaign, we need to raise awareness, yes, of HIV and STIs more generally, for the population as a whole, and we need to promote condom use. So I think that is the context of our campaign, particularly, as I say, it will be targeted for the 18-30 population.

103. What actual evidence have you got that fear does not work, or does not work as well as (persuasion ?) ?

(*Ms Hamlyn*) We have evidence from campaigns, actually both here and abroad, I do not know if anybody else could qualify that for me, in terms of research that has looked at what works and what does not work. If it would help the Committee, I can pull out the references for some of that research.

Chairman: That would be helpful, thank you.

Mr Burns

104. That would be, yes. Can I ask just one other thing as well. Given that, in certain of these areas, more and more evidence is becoming known, that was not known five years ago, or whatever, how quickly can the Department, as a sponsoring Department for health education, booklets and leaflets, providing straightforward practical information and advice to different target groups, respond to the changing medical-based evidence? I raise this specifically because, I do not know if any of you are aware, but no doubt other officials in your Department will be aware, that the Department of Health has had some ongoing correspondence with a number of Members of Parliament involving an issue that one individual brought to these MPs' attention, which was to do with HIV and oral sex. And it seemed to me, to be fair to the relevant Minister, who was Yvette Cooper, at the time, that what the Department said they were doing on the increased knowledge of the problems, or the potential problems, they were responding in what I certainly considered to be a reasonable way, though there was a criticism from the person particularly concerned that the timescale was not quick enough. And you have now, and I think it is the Terrence Higgins Trust with their booklets, changed the phraseology in that section, but it took some time, and the Government argument was, you know, "We have got X tens of thousands of these booklets, and it's a relatively minor part of the whole area, and when they run out they will be redone, replaced and updated." Is that a reasonable situation to be in, because scientific evidence is changing the whole time, and you cannot just pulp a whole section of booklets and advice given out every time there is a change, unless there is something really dramatic; and what you did was a perfectly reasonable way to approach it, and that is the way you will continue to approach this area, with increased medical knowledge?

(*Ms Hamlyn*) I think there are a number of points I want to make. More generally, in our Action Plan, we have referred to a review of leaflets in general, and I have already commissioned that piece of work; that is looking at the availability and how leaflets get used by people, users of services; and, indeed, it is leaflets not just produced by, or funded by, the Department, but through the professional bodies. And there are issues about, all sorts of issues, in relation, that have started to come out about that, about how people access that information, how it is used within a medical context, and, indeed, where they need updating, whether people, professionals, at a local level, are aware whether they are using the most up-to-date piece of guidance. And we do need to look at issues such as simple things that can be put down, to put dates on documents, that we can have mechanisms to withdraw, systematically, documents, where we need to, where we need this change, and where we can make aware to professionals in the field about a new document. Those are some of the measures that we are looking at, more generally, on leaflets, to do, whether they are ones that we produce directly or whether they are ones that are funded through another organisation.

Siobhain McDonagh

105. I want to look at the area of contraception and terminations. How will you address the staffing shortages in community contraceptive services; and in the document you make much play of having different sorts of facilities, both at GPs' and contraceptive clinics themselves? But, in my own experience, from my own area, which is a part of

[**Siobhain McDonagh** *Cont*]
south-west London, those community contraceptive clinics are closing, rather than opening, and now almost exclusively, particularly in the less well-off parts of my borough, which is the London Borough of Merton, GPs really are the only people who are providing a contraceptive service?

(*Ms Hamlyn*) Yes, I have heard a number of examples of that, and certainly through my visits across the country people talk to me about the issues of difficulties of recruiting staff into the profession, and being able to retain staff; so there are a number of issues that we need to pick up, as part of our overall Workforce Strategy. On the issues particularly of staffing levels in community contraceptive clinics, there is likely to be, if you look at the numbers in consultant posts, again look at senior clinical medical officers and the numbers going to retire, there are issues whether we are going to keep up with the numbers that we need to have, in terms of consultant posts and associated specialist posts. And the Royal College, the Faculty is pursuing that issue, looking at additional training programmes, looking at how that can be addressed. Also, this year, we have funded the Royal College of Nursing to develop a distance learning pack for nurses, and, of course, not everything in community clinics is done by doctors, and again there are the skill mix issues. Now having a distance learning pack will help, but clearly it is not going to solve the whole problem. And I think it comes back to the wider training strategy that we intend to develop, which is intended to look at all professional groups, it is intended to look at what is available, in terms of training, intending to look at the issue within the workforce study, the issue of training posts, and the issue of different types of staff that can be used for different purposes. There are very good examples across the country where you do not need doctors to run a contraceptive service, you can have nurse-led services, we have the role of pharmacists now providing provision of emergency contraception, and you have examples of services, indeed, where youth workers, social workers can have a role in providing advice, and, indeed, the distribution of condoms. So I think there is a range of different issues that can start to address, quite rightly, the problems that you are mentioning.

106. And how will you address the current iniquity of access for termination of pregnancy services; here, it has got particularly for rural populations, but I have a case with me of a GP who has recently written to me, again, in south-west London, concerned that his patient had to wait in excess of five weeks for a termination at a major London hospital?

(*Ms Hamlyn*) Through the strategy referred to, the issue of actually trying to address the issue of access to abortion, and indeed we are setting a standard that PCTs need to ensure that women who meet the legal requirements for abortion have access to abortion within three weeks of their first appointment. That is a standard that we expect PCTs to start measuring against, and, indeed, our intention would be that by 2005 that standard is fully adhered to.

107. May I just ask you a question about that target. Surely, the answer then will be to delay longer before you get your initial appointment; if it is only three weeks after you have seen the consultant?

(*Ms Hamlyn*) It is the first referring doctor, we are talking about.

108. So the GP?

(*Ms Hamlyn*) It is three weeks from the first referring doctor is the issue. Now we do know that there are issues; this standard is intended to address some of the issues of waiting that you are talking about, and, indeed, some of the issues where local commissioning policies can be quite restrictive, and we do know examples, like you quoted yourselves, we know a particular, difficult issue for the younger age group, young teenagers tend to present late and then it becomes a real, big issue, and particularly if they have got to travel distances. So I think we are very serious about addressing this as a particular standard, it is in our Action Plan. Through the Commissioning Toolkit, we will be incorporating good practice, in respect of abortion services, again to provide easy access and to be obviously the standard that we are setting.

Julia Drown

109. Just carrying on from that, even three weeks is quite a long time to wait?

(*Ms Hamlyn*) It is a maximum. Clearly, one of the debates that people have had is that, for some women, they need the opportunity of thinking about whether it is the right decision for them. I think it is a balance between not rushing women straight in, but actually having a reasonable time. It is in accordance with the Royal College of Obstetrics and Gynaecology, so it is a guideline that is consistent with the Royal College.

110. But, for those who have firmly decided, would your aim be something much better than that?

(*Ms Hamlyn*) I would hope that they have a very smooth, easy access actually into services, yes, when they want a service.

111. The other thing I wanted to ask about was encouraging better methods of termination, safer methods that do not involve general anaesthetic; what are you doing to encourage that, and will you be funding any such facilities being developed, particularly in Primary Care facilities?

(*Ms Hamlyn*) In our Action Plan, we have referred to our pilots, of looking at termination of pregnancy in non-traditional settings, but within the law, and also looking at improving early termination, which avoids the issue of medical complications, in terms of later termination. So those are pilots that we would be taking forward, as part of the Action Plan.

112. And we have got those details in the Action Plan?

(*Ms Hamlyn*) It is in the Action Plan.

John Austin

113. I want to come on to toolkits and piloting in a moment, but can I just go back to this issue of mainstreaming versus ring-fencing, and ask, what is the future of the AIDS support grant that is made to social services departments for the care of people with HIV and AIDS?

[**John Austin** *Cont*]

(*Ms Stanier*) We are currently reviewing that grant. We do feel, in particular, that there is a need to simplify its administration, because at present we ask local authorities for estimates and then we allocate funding on the basis of those estimates, and then we do a second process in year. But there is certainly scope for simplifying those procedures.

114. But is there a risk that it may get lost in the just general grant allocation, resource allocation, to local authorities, or will it still be specific?

(*Ms Stanier*) It is the case, as you are aware, that there is a general move towards more mainstream provision of funding, both for the NHS and local government; so that certainly is a possibility, but the review will be concluding later this year.

115. But there will be systematic and careful monitoring of what happens in local authorities, if you change the system?

(*Ms Stanier*) We would approach it in exactly the same way as we have for HIV mainstreaming, to make sure that proper management arrangements are in place.

116. But you have referred elsewhere, evidence has referred elsewhere, to somewhat cumbersome data exchanges between the Department of Health and health authorities; what steps have you got to improve that, and what is the role of the Health Development Agency?

(*Ms Stanier*) If you are referring, in particular, to the AIDS Control Act returns, it is equally the case that we are in the process of reviewing those returns, with a view again to make sure that we are only asking for information that we really need, and that we make good use of that information, for example, by collating it at a national level and actually publishing the findings. The Health Development Agency do not have a particular role in that process.

117. So what is their role?

(*Ms Hamlyn*) The Health Development Agency, we have, in fact, commissioned them to pull together the best possible evidence of what works, in respect of HIV and STI prevention, and that is very much in terms of their role about drawing together evidence, not new research but reviews, and that evidence will be made available to the field.

118. Can I come on to the issue of the implementation of the strategy and the toolkits, which you mentioned, which, clearly, you see as critically important for the success of the strategy. To what extent have the providers and patients been involved in their development, and how will they be piloted to ensure that they are valid?

(*Ms Hamlyn*) In both cases, in terms of the Health Promotion and Commissioning Toolkits, our date of completion, is set out in the document, so we are not talking about until late summer or autumn to publish those, so it is not the case that we have a document now. During the consultation period, the idea of having a Commissioning Toolkit received overwhelming support, and the process by which that is being developed will involve a number of people from the field, who are already involved, in terms of professionals in the field. As I have also referred to, in the Action Plan, it is the intention to set up ongoing methods for user involvement, at a national level, and there are currently arrangements by which we use various mechanisms for involving through key national voluntary organisations, in terms of user involvement, currently, but we need to substantiate that. And those are the kinds of mechanisms that we will want to use, in the development of both these Toolkits, and indeed any further guidance that we want to produce.

Dr Taylor

119. We have talked a bit about PCTs, and the tremendous responsibilities being devolved to them, and I am terribly worried about them, particularly those that have only just started this year, and whether they are going to have the capability of really doing everything. Now do you have plans actually in place to ensure that PCTs are equipped? In your Implementation Plan, they have to identify a sexual health and HIV lead, with appropriate level of seniority and public health expertise. Are there enough of these people around, and, generally, what support are you going to give the PCTs with this crucial role that they have not actually had before?

(*Ms Hamlyn*) In every PCT there is now being appointed, and the vast majority have been appointed to date, a director of public health, and within every PCT there will be health promotion, people with a health promotion background, previously who had worked for health authorities, and there may be arrangements whereby one takes a lead on behalf of PCTs. So there are the people there. We have asked for every PCT to identify a lead, we have not got a full list of those at the moment, but we intend, obviously, to get a full list of those, and the intention will be to really create that into a network, a network where we can ensure that they get all the up-to-date guidance and information, that we can build in through seminar programmes to develop their own skills. We are looking at what kind of support can be made available at a regional level, through the regional public health groups. The Commissioning Toolkit that I referred to earlier, our intention is to have seminar programmes, to invite these leads to, in the autumn, once that is available, and there will be similar programmes, seminar programmes, for the Health Promotion Toolkit. So we are building in training and development as part of really developing that capacity, which we feel is key for the success of the strategy.

120. And is there any guidance, if you have got a partnership between several PCTs, and one of those PCTs is taking the lead on sexual health, will that one lead work across the three PCTs, or will each PCT have their own?

(*Ms Hamlyn*) We think it is perfectly acceptable for there to be one PCT leading, if that is the local arrangement. Who gets involved in our training and development, I think, is for them to tell us about who they would want us to communicate with, involving their training. But we would find it acceptable if one PCT were to take the lead and identified a collaborative arrangement; it is equally acceptable for each PCT to have a lead.

121. And what is the role of the Strategic Health Authority?

[Dr Taylor *Cont*]

(*Ms Hamlyn*) The Strategic Health Authority has a performance management role over PCTs, so they will be discussing with each PCT about progress to meeting the standards and guidelines that we will be producing, and the development of a local strategy. So really it is a performance management role.

Julia Drown

122. Can I just pick up some of the issues that were brought to our attention from the Family Planning Association's evidence to our Committee, which is what you are going to see, and just first of all picking up some of their issues on abortion. You said earlier that you are doing these pilots, and have seen the Action Plan in other settings, where it is legal; would those include family planning and community clinics?

(*Ms Hamlyn*) We are talking about in the context of the law, and I do not know whether Andrea would like to comment.

(*Ms Duncan*) The law currently says that abortions can only be performed in an NHS hospital vested in a PCT, or what used to be a health authority, or in a place approved by the Secretary of State for Health.

123. So the Secretary of State for Health could approve any area, if they wanted to?

(*Ms Duncan*) But, at the moment, the only places approved by the Secretary of State are in the independent sector, that is (BPS, MSI ?) type.

124. But, presumably, it would not be a big, it is not primary legislation to change it?

(*Ms Hamlyn*) What we want to do is to pilot, there could be examples where you have what is regarded still as a hospital site, but actually is now, because of the development in that particular area, it is actually more a community setting, where we can actually pilot it to see how it works, and then we can actually consider whether that will inform us about the issue about any changes the Secretary of State might wish to make.

125. So we are not yet dealing in family planning or community clinics, probably?

(*Ms Duncan*) There is a facility in the Human Fertilisation and Embryology Act that the Secretary of State can approve a class of place[7], so we do not have to take applications from individual places, and so these pilots will inform what we can describe as a class of place.

126. The other thing they suggested was that nurses should be able to undertake abortions; are you looking at that?

(*Ms Duncan*) That would require a change in the current law, because the law says that abortions can only be undertaken by a registered medical practitioner.

127. Any views on that though, is that something that is being raised with the Department?

(*Ms Hamlyn*) I do not think it has, actually, been raised with us specifically, no.[8]

128. And, in dealing particularly with the delays, that obviously women do not want to have, obviously one big request is for abortion to be available on request, in the first trimester; what evidence do you have that would actually smooth the process, lead to a reduction in people having to have very late abortions when an earlier one obviously would be much less difficult for them, and for the NHS?

(*Ms Stanier*) When you say "on request", do you actually mean a change to the current arrangements for securing two doctors' signatures?

129. Yes.

(*Ms Stanier*) Well the position is that the Government really does not have any plans to look again at those arrangements.

130. But do you get any feedback on whether that would actually help, in terms of giving women abortions more timely, and avoiding them having to go very late and it being more difficult for them and for the NHS?

(*Ms Stanier*) I am not aware that we have had any such representations, or seen any evidence on that.

131. The Family Planning Association are also saying that the information on sexual health is very patchy at the moment, and a particular feeling that materials are not accessible in other formats, large print, particular languages, community ethnic minority languages, Braille, audio, and so on. What steps are being taken to address that?

(*Ms Hamlyn*) Those issues are being looked at in the context of, as I referred to, this review of information leaflets, and what is available to the public and how they are being used.

132. They pointed out also about, in particular, their information lines, but how they are not integrated with NHS Direct; is that something else that you are looking at as well?

(*Ms Hamlyn*) We have had discussion with the FPA in thinking about what should be the model of helpline provision, particularly in the thinking about the context of having a campaign, for the people that may need to 'phone up a particular service. And I think we had to distinguish between, here, an information line, where people get basic information, a line where you have a professional back-up, that the FPA currently operate, and NHS Direct, I think, is clearly where some people might argue that, if that became the main vehicle, that maybe sexual health will be normalised. But there are some issues about the approach that is taken in NHS Direct, and, in particular, that people are asked their name, and so on, but actually when people want to 'phone up, they want to remain more anonymous than that. So we are not convinced that actually having NHS Direct as the main first point of reference for our campaign is the right vehicle, but we do feel that there clearly need to be very strong links with NHS Direct,

[7] *Note by witness:* For medical termination of pregnancy.

[8] *Note by witness:* The British Pregnancy Advisory Service raised the issue at a meeting with the Department in November 2000 but were informed that under the current law only a registered medical practitioner can undertake a termination of pregnancy.

[**Julia Drown** *Cont*]
because some people will go through NHS Direct. And the FPA does work already in close concert with NHS Direct, as indeed do other helplines.

133. One very interesting question. It is rare, in officials, to have a panel of all women; any idea why? And there are quite a few women consultants in GUM; why?

(*Ms Hamlyn*) I think it is probably the case that in sexual health as a whole, certainly in most of the places that I go to, there is quite a predominance of women.

Julia Drown: Why

Chairman

134. What conclusion do you draw, why is that, because it is an issue we may want to address, quite seriously?

(*Ms Hamlyn*) Yes, that issue has been raised, but, in fact, for health promotion work with men, that you need more male workers; that is an issue that is raised.

135. Any thoughts on what we do there?

(*Ms Hamlyn*) There is some very good work going on within our Teenage Pregnancy Programme, on young male workers; we were actually trying to bring them together, in terms of a network which can support and encourage them, and hopefully, therefore, we might attract more people into the field.

(*Ms Stanier*) We also have one male member of our team here today. I would not like to say that our whole team is women.

Chairman: He is sat on the floor.

Sandra Gidley

136. Just a quickie. I have had a number of letters from people who seem to be concerned, and I do not know where they get this idea from, that, with the changes that are mooted, I think they think because sexual health is going to be the responsibility of the PCTs, there seems to be a feeling that somebody has got hold of that you have to go to your doctor to access these services. I just wondered if you would comment on that, because not everybody would feel comfortable going to their GP?

(*Ms Hamlyn*) There was some confusion that came out during the consultation process about our model of service, and we did refer to wanting to see an effective Primary Care service and the role of Primary Care; but we were really talking about Primary Care in its widest sense, and not just about general practice, in that context. So, yes, there were some people who thought that we were talking about disinvesting from other services and putting everything onto the GPs, and that is not what we are talking about, we want to improve choice of access, yes, for people in a local area, but there is a range of different ways that can be provided, and, yes, general practice has a part to play, but they are not the only part to play.

Sandra Gidley: Thanks for clarifying that.

Chairman: Can I thank our witnesses for the helpful session. You promised us some additional pieces of information, which we look forward to. We are very grateful for your co-operation. Thank you very much.

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